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ORIGINAL LECTURES.

ON SCROFULA.

A Clinical Lecture delivered at the Good Samaritan Hospital, Cincinnati.

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(Reported by JAMES M. FRENCH, M.D.)

GENTLEMEN: I bring before you this afternoon a little negro child suffering from a disease that is very common to its race. What it is, I shall ask you to tell me after you have heard the history of the case.

The child is now fourteen months old. You observe that it is somewhat emaciated; and, although a negro, you can see that it is anaemic, its head is of the type which we call the square head, and the fontanelle is still large and somewhat depressed. You see further that the child has a flat nose, from which there comes a bloody seropurulent discharge. The upper lip is very much swollen; the lower lip is also somewhat thickened, and at the corners of the mouth we see fissures with infiltrated edges. Continuing the examination, we find that there is a tendency to a chicken-breast, and that the child has a "frog's belly." The epiphyses are enlarged, especially those of the wrist-joint and of the lower extremities. The lymphatics about the neck are very much enlarged. There is no enlargement of the epitrochlear glands, but the axillary glands are infiltrated. The genitals, the soles of the feet, and the palms of the hands are perfectly free from signs of disease. Examining the mouth, we find that upon the tongue and upon the sides of the cheeks there are whitish patches, which, when removed, leave a bleeding surface.

The case is now ready for diagnosis. What is it? Among the answers that I receive I hear the word "scrofula;" and that is what I expected. This is a typical case of scrofula; you could not desire anything more perfect. Here is a child that has a skin-disease; it has enlargement of all the lymphatic glands; it is troubled with mucous membranes; what more would you wish? Now let us see what the disease really is. We have here all the symptoms of a rickets that has probably about completed its course. So far as I know, it has now no symptoms of the disease. The child has other manifestations, however, which were formerly classed under the head of scrofula—a *great many years ago*, we like to say—yet it is not many years; and some prominent members of the profession still use the term.

The eruption to which I have called your attention is best seen about the angles of the mouth. It is best described as a fissure with extensive infiltration of the surrounding tissue. There is, further, an eruption behind the ear—rather an unusual place for it to appear—an eruption that is also surrounded by an infiltration. In addition to this the child has, as I have told you, a flat-

tened nose, and there comes from it a discharge which has an exceedingly offensive odor, and consists of blood, pus, and serum: It is also very irritating, and it is to this irritation that we must attribute the eruption and swelling of the upper lip. You have heard, also, that the child has universally enlarged glands. With this condition of things there is but one disease to be thought of. The fissure about the angle of the lips is, in fact, sufficient for us to make our diagnosis. When I first saw the eruption behind the ear, day before yesterday, it appeared as two discrete infiltrated spots, each the size of an old-fashioned silver half-dime, but they have since blended into one.

There is but one disease to be named, I say, that is hereditary syphilis. If, on the other hand, we had only this peculiar nose, characterized not only by a flatness of the bridge (not always present), but also by a seropurulent discharge, very thin, and of an exceedingly offensive odor, and streaked with blood, we should have to consider *two* diseases before deciding upon our diagnosis. We should have to consider a catarrh arising from tubercular deposits, and a syphilitic catarrh. We have here a disease known as *ozæna*, so-called because of the offensive odor of the discharge; and when in the presence of this disease, we are always justified in thinking of but two things, namely, a catarrh due to tuberculosis, and a catarrh due to syphilis.

In this regard recent investigations agree in every particular with the theories that have been held for a number of years. When I speak to you to-day of these troubles, I speak to you with authoritative knowledge, and not theoretically, as I formerly had to do. If, now, you take a large number of these cases of *ozæna* and examine the discharge from the nose for the bacillus tuberculosis, you will find them present in the great majority of instances. One of the most interesting cases of this kind was reported by Démme. A child was brought to him with an affection which he pronounced nasal catarrh of tubercular origin. The tuberculosis ultimately extended to the meninges, and the child died of tubercular meningitis. We have all hitherto been underestimating the importance of these local manifestations of tuberculosis. It has been my custom for years to point out to you the relation which I believed to exist between these local troubles and general tuberculosis.

You are justified in calling every case of *ozæna* a tubercular catarrh, or a syphilitic catarrh. Examine for the bacillus tuberculosis; if you find it, you know that you are dealing with a tubercular affection; if you do not find it, you are justified in pronouncing the disease one of syphilitic origin.

We have in this child a late manifestation of syphilis. There can now be no question about the case, except in regard to the possibility of the existence of tuberculosis in addition to the syphilitic trouble. It is not uncommon to have both these processes going on at the same time in the general system, or in the lungs alone. If you were to find in this child, in addition to its syphilis, a

tubercular process, your prognosis would of necessity be pitched at a much lower grade than otherwise. The child has at best a strong enemy to fight.

[Subsequent examination failed to discover the bacillus tuberculosis in this case.—REP.]

Looked at from this standpoint, the whole subject of scrofulosis becomes very plain and simple. Looked at from the standpoint that it is either tuberculosis or syphilis, and that in probably ninety-nine cases out of a hundred it is tuberculosis, the subject of scrofulosis becomes very simple; but if you look through the literature of the subject for several hundred years in French, German, and English, you will be surprised to see how much of vague conjecture has been written upon it. Before his discovery of the bacillus, Koch claimed that tuberculosis and scrofulosis were identical in origin but he had no proof of the identity. It had been claimed that scrofula was simply a clinical picture, of really little importance—that it was, in fact, only a convenient name for the peculiar combination of symptoms that are presented in this case. The great objection to this term is, that while it is sufficiently applicable as long as it is used in a scientific way, it has, by a too general use, become degraded so as to be but little more than a mask for ignorance.

Let me give you an example of this. I have, within the last few weeks been called to see two cases in different families. In the one case the child had a profuse eruption covering its face, its neck, and its buttocks. I looked at the eruption carefully and found that it was an eczema. Of course the lymphatic glands were all enlarged. Upon inquiring into the history of the child, I found that Dr. So-and-so had treated it—that is, he had been giving it medicine internally—but the child had gotten no better. They tell me also that Dr. So-and-so, another physician, had not only given the child medicine, but had also put the mother upon a special diet, not permitting her to eat certain articles of food of which she is very fond,—probably the reason for his dismissal—but the eczema has gotten no better. Finally, under proper treatment, based upon a correct diagnosis, the child improved, and is now practically well. Here is a practical illustration. The physician who was called before me either thought that the child had hereditary syphilis, which would have been a mistake, indicating that he did not know his business, or, to be more charitable, he called the case one of scrofula and treated it for—he knew not what. Now he has by this mistake done harm both to the case and to himself, for the child could have been well long ago. Such practitioners reason, that because the child has an eruption and enlarged glands, it must have scrofula. Now all of you know that where there is an eruption of the skin, the neighboring glands are all enlarged. I do not deny that these glands that are enlarged from the irritation of an eruption in the skin are more likely to have developed in them the bacillus of tuberculosis than are healthy glands; but these gentlemen make an incorrect diagnosis and treat the child accordingly, with no results.

The second case to which I refer was a child about eight weeks old, in an excellent family. When the child was about four weeks old, an eruption appeared about the nose and corners of the mouth. It appeared also on the forehead and on the soles of the feet. This

child had been treated by a physician who called the affection scrofula. I had no hesitation at all in going one step further and giving to the disease its proper name, "infantile syphilis." I put the child upon proper treatment and it recovered. These are simply examples of numerous cases that I could mention.

What now is there to be gained by using the term scrofula? Nothing. It is simply a term which, like a great many others, we use to cover over our ignorance. It has no actual value, and in that respect resembles paper money. I want you to fix this point in your minds, that scrofula is either tuberculosis or syphilis. Some cases however are called scrofula by many practitioners that are neither the one nor the other. Some are called scrofula which, like the first case that I narrated to you, are nothing but eczema. Any rational physician would not call such a case as that scrofula, for he would certainly know that the lymphatics which take away from the affected part its lymph, or supply lymph to it, must be enlarged. So, whatever be your views as to the origin of the eczema, whether you be a "localist" or a "constitutionalist," you have no right to call a case scrofula simply because the lymphatic glands are enlarged. As I told you before, we do more than theorize in regard to this subject; we make our diagnosis positive by examining for the bacillus tuberculosis. Not one of you should go out from this College until he knows how to examine for this bacillus, so important is such knowledge not only for the scientific investigation of disease, but also for diagnostic purposes. The process for its detection is not at all difficult, and when it is made, we have something that is positive. Wherever we find these bacilli, we know that the tubercular process is going on. It is true that it has taken away a good deal of the dread that we formerly had for the disease. We know now that it may be local, and not only that, but that it may be for a long time localized. Yet we know also that, from this local focus, there may come general tuberculosis, and hence the great importance of it to you as practitioners of medicine is that you may be able to detect the primary local focus and then endeavor to remove it. In cases in which there is incipient phthisis, you may sometimes detect the disease long before there is any positive physical evidence that would warrant you in making any great change in the habits of the individual, or advise a change of climate. I feel very sure that I have saved a number of lives as a result of this brilliant discovery of Koch, simply by having the patients secure at an early period of the disease the benefits of a change of climate.

Now, to return to this case. What shall we do for it? These large sores, these papules are to have applied to them *unguentum hydrargyri fortior*—the stronger ointment of mercury. This is put upon pledges of lint, retained by a cap over the head. I do not know of any dressing that works with greater rapidity or with more certainty than does this stronger ointment of mercury, especially in the softer or papular forms of eruption wherever we find them.

What do we give this child internally? We give the iodide of potassium, especially for its effects upon the nose. I shall have this child brought before you at our next meeting, in order to show you the improvement we shall have obtained in the case by that time. You

will find that the iodide works wonderfully in these cases of *ozæna*. The first improvement is that the discharge becomes less offensive in odor, the next that it becomes less in quantity. If the child becomes thoroughly under the effects of the iodide, the discharge becomes greater in quantity again, but it is a different kind of discharge.

Having, now, this form of eruption in the mouth, having made the diagnosis of syphilis, you would intuitively come to the conclusion that the eruption was due either to the syphilitic infection or to long-continued mercurial treatment received before coming to us. In regard to treatment, we know that the child has not been treated by mercurials for the simple reason that we do not find here a mercurial stomatitis. We have not the characteristic eruption of mercury. We have not the red line about the gums, we do not have the salivation, or the offensive odor from the mouth. Neither is this a syphilitic stomatitis, and why? In the first place it is not localized as a syphilitic stomatitis ought to be; it does not appear where a syphilitic stomatitis generally occurs; that is, about the posterior segment of the mouth. This alone would not be sufficient to exclude syphilitic stomatitis, but if you look at one of these small spots carefully, you will see that it is made up of a layer of necrotic tissue beneath which there seems to be perfectly healthy mucous membrane. If you strip up this layer, you turn back a mass of dead epithelium, and you find that in the centre it leaves a healthy mucous membrane, while at the periphery it leaves a bleeding surface. What then is it? I have no hesitation in saying that it is simply a case of *stomatitis aphthosa*, *aphthous stomatitis*. What shall we do for this? Nothing beyond keeping the mouth clean and having it washed out freely with the best disinfectant for the mouth, namely, the chlorate of potash in solution. By the time the child comes before you next week, this trouble will be entirely relieved. And the chances are that before that time the papules about the mouth and behind the ear will have begun to heal, and you will find, I hope, that the child's nose will be in a much improved condition.

The leading truth which I desire to impress upon you to-day and the lesson which I wish every one of you to carry away with you is the relation that exists between so-called scrofula and syphilis.

ORIGINAL ARTICLES.

CASES BEARING UPON CERTAIN MOOTED POINTS IN SYPHILIOLOGY.¹

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THE EXCISION OF SYPHILITIC CHANCRE.

CASE I.—In 1884, a medical gentleman from a neighboring State called at my office to show me a small pimple situated upon the middle portion of the integument of the dorsum of the penis. This lesion was an acuminated papule, not capped by a pustule. The epidermis was unbroken. The color was slightly livid, the size about three-sixteenths of an inch at the

base. There was no appreciable induration, indeed the lesion had no pronounced specific character. It was not painful. There was no inguinal glandular engorgement. The lesion had appeared during the afternoon of the day before I saw it. It was less than twenty-four hours old, and the patient ascribed it to suspicious sexual contact dating back two weeks. The integument of the penis and of the rest of the body was normal, the general health good.

A diagnosis was impossible, although the general appearance of the lesion suggested an accidental papule, and would have justified a favorable prognosis as to syphilis. Yet the patient was solicitous that something should be done.

Cocaine as a local anaesthetic was just coming into use, and I proposed to him excision with the aid of this agent. He gladly accepted the test. I washed the unbroken surface with a powerful solution of bichloride of mercury, one in two and a half, dried it, injected five minims of a four per cent. solution of cocaine under the skin, caught up the little papule with a full margin of the ample soft integument around and with scissors curved on the flat excised an abundant fold, including the lesion and considerable healthy tissue around.

Two catgut ligatures upon bleeding veins and three catgut sutures promptly finished the operation and left the wound absolutely dry. The patient had not experienced a particle of pain.

On his return home the doctor visited the suspected party and found that she had a syphilitic eruption.

The wound healed promptly by first intention. On the sixty-second day, after three or four days of premonitory fever, no medicine having been taken, the patient observed a mild roseola, which promptly disappeared. Fourteen days later he visited me. He had lost eight pounds in weight. In one groin were two indolent indurated glands, one in the other groin. The site of the excised chancre was soft and perfectly well, showing only a faint linear white scar. There was intense rheumatism, worse at night. There were scabs in the scalp, and the hair was falling. A profuse general papular syphilide covered the entire trunk, the face, and both the palms. Mucous patches abounded in the mouth. The eruption was brilliant and abundant, the patient pallid.

The disease had not been interfered with by any medical treatment, and was a plain instance of a sharp attack of syphilis which had not seemingly been in any degree modified by the excision of the initial lesion, although executed under unusually favorable circumstances.

This case I consider worthy of record because it fulfills the most exacting conditions for testing the question, still under consideration in the profession, as to whether syphilis is or is not already a constitutional disease when the chancre appears.

I do not care to tabulate statistics of the excisions practised by various operators. The résumé of Dr. Morrow,¹ in December, 1882, covered enough cases to allow generalization, and nothing which I have seen since that date has modified the conclusion he seemed justified in drawing; namely, that the ex-

¹ Read before the New York Surgical Society, April 14, 1885.

¹ Journal of Cutaneous and Venereal Diseases.

cision of chancre does not attenuate the poison of syphilis or modify the general symptoms.

Berkeley Hill's case,¹ it appears to me, carries more weight than any other reported before or since. A man tore his *frænum* during intercourse, at 4 A. M. At 3.30 P. M. on the same day—less than twelve hours after exposure—Hill destroyed the entire raw surface with fuming nitric acid. An eschar separated and the wound healed. A month later the cicatrix indurated and general syphilis followed.

My own opinion has been strongly opposed to the belief that local excision of chancre would prevent or modify general syphilis. I have offered the treatment to many, but as I never felt conscientiously at liberty to promise any advantage as a result of the operation my proposition has been declined. I would not have operated in this case except to test the cocaine, and because the patient, being a physician, earnestly desired it.

My case is quite analogous in its history and result to one reported by T. W. Taylor, in which² a papule was excised upon the day on which it appeared—with no advantage to the patient, whose general symptoms came out in two weeks. It is on a par with others in which early excision was practised in vain (Mauriac, forty-eight hours).³

I have recently also encountered another case in point (unpublished).

CASE II.—X., aged 37, came to me in January, 1885, stating that in November, 1883, he noticed a small chancre on the penis. This was excised on the first day and the wound promptly healed. In six weeks he had a general roseola. He is now in his second year, having had numerous eruptions and been plentifully treated in various ways, including forty-five grain doses of the iodide of potassium three times a day, and a course of eight weeks at the Hot Springs, during which time ten ounces of blue ointment were rubbed into him. He came to me for some small gummatous tubercles upon the face, and is still under treatment. In this instance surely the excision did not favorably modify the intensity of the disease.

A medical friend, who wishes to be nameless, has recently reported to me a case of excision within twenty-four hours of the appearance of the lesion, in which general symptoms (roseola) appeared upon the thirty-second day. In other words, it has not been my good fortune to meet any case in which excision was practised with a favorable result.

I think it not difficult to understand how apparent success may follow excision, when we remember the multiple sources of possible error in diagnosis, and particularly is this the case in Germany, where the best results are claimed (thirty to fifty per cent.), for here the advocates of excision are all unicists (notably Anspitz and Kaposi), and are doing their best to return all primary venereal sores into that chaos from which Bassereau and the French School have endeavored to deliver them.

The sources of error to which I refer are :

1. Inflammatory induration of lesions not syphilitic.
2. The small ulcerated gumma of the penis.
3. Non-specific sores which resemble the infecting chancre.

4. Cases of delayed syphilis.

I need not cite instances of the first two classes mentioned above. We are all familiar with the local sore of unknown incubation, with a hardness so nearly typical that we cannot ignore its peculiar quality, yet where observation without treatment has proved the absence of any true venereal taint.

The localized gumma commences as a tubercle under the skin, has all the essential hardness and sometimes the inguinal indolent adenopathy. Its physical characters might deceive any one. It may come upon one in seemingly vigorous health and be the only lesion present. The patient may have forgotten his old syphilis, the last symptoms of which occurred perhaps ten years before. I have had more than one such case.

If now this individual has had suspicious sexual contact a month before the sore appears, he is very apt to be considered a case of reinfection. These localized gummata (pseudo-chancres) have a marked partiality for occupying the site of the original chancre, but this is not an invariable rule.

Of the third class—a sore resembling, but not being a specific ulcer in any poisonous sense—I have seen a number of examples. The most striking is the following. I have no theory upon which to explain it, but can affirm that I have never seen a more typical excoriated induration as a starting point of syphilis than was this simple inflammatory hardening.

CASE III.—A young man came to me about two years ago with a tight foreskin and a contracted preputial orifice, from which a moderate amount of pus exuded. In the substance of the prepuce at about its right lateral centre, was a hard disk with clearly defined margins, insensitive, giving to the fingers about the feel one would expect to get from a disk of gutta-percha set into the foreskin. The patient could retract the foreskin formerly, and assured me that he had seen an ulcer on the inner surface of the hard spot so long as he could expose it to view, which of late had become impossible. The sore had appeared one month after intercourse. There were two or three indolent indurated glands in each groin.

This boy had consorted only with one female. She would not allow herself to be examined. She shared her favors among a set of young men, of whom several had been patients of mine for various disorders not syphilitic. These young men continued to consort with this woman before, during, and after the date of the alleged exposure in this case. All remained well excepting one, who acquired mild urethritis from intercourse too near the menstrual epoch. After a local treatment of several weeks I was enabled to retract the foreskin and inspect the lesion. It proved to be a simple livid excoriation upon a sharply defined induration. There had been no true ulcer. The whole physical appearance of the lesion was that of infecting chancre. I concluded that it must be due to mediate contagion.

No internal treatment was ever given. I watched

¹ Venereal Diseases, 1883, p. 310.

² Syphilis and Local Contagious Disorders, Hill & Cooper, 1881, p. 76.

³ Ann. de Derm. et de Syph., July, 1881, p. 523.

the case several months. The excoriation healed; the induration disappeared. No symptoms of syphilis followed.

This case is unique in my experience. I believe it to have been an unusual form of simple inflammation, traumatic in origin, due primarily to the tightness of the foreskin.

If it was syphilis, it was delayed syphilis.

I have seen a number of other traumatic lesions which might have been mistaken for the starting-point of syphilis, but nothing so seemingly typical as this case. In any event such cases are not common.

DELAYED SYPHILIS.

CASE IV.—A gentleman of 37 called upon me in September, 1883. He stated that he had had an ulcer on the penis in August, 1880, which appeared three months after exposure. This was the first venereal symptom he had ever observed. The sore was treated locally. It healed within two weeks. No symptoms followed.

In April, 1883—more than two and a half years after the alleged chancre—he fell into a sort of stupor, with fever and rheumatic pains, especially of the feet. After three weeks a spotted eruption came out upon his palms, which was pronounced to be syphilitic. Then his throat got sore, ulcers appeared in the mouth, the hair fell out freely, and, having been taking antisyphilitic treatment already for a few weeks, he became alarmed, and went to the Hot Springs. There he was treated actively. In July he had some ocular trouble, which improved at the Hot Springs. At my examination I found two characteristic palmar desquamating spots, and some mucous patches in the mouth.

This case, of course, allows a suspicion of a new infection in March, 1883; but the patient, who was absolutely free in giving his history, disclaimed it.

CASE V.—X. aged 30, visited in November, 1883, stating that five years previously he had a local set of lesions on the penis for which he received no internal treatment. He remained well for one year. Then painful lumps appeared under the scalp, the throat ulcerated, the bones of the nose came away, the middle ear suppurated, rupial eruptions, scaling spots and papulo-squamous patches came out upon various parts of the body, then he got heart-flutterings, dyspnoea, vertigo, dyspepsia. The patient denied any venereal malady up to the time of the sores first mentioned above.

Anything so irregular as these two cases, of course, is a matter of suspicion, but the unexpected element in syphilis is so common, and irregularities from the normal type so constant, that I think it possible to accept them as instances of irregular or delayed syphilis.

These last described forms of disease capable of causing error in the diagnosis of syphilitic chancre are very uncommon, the first two inflammatory hardening of chancroid and local cutaneous gumma resembling chancre, are very common. Whether it is possible that observers so renowned as the German advocates of the excision theory could be mistaken in their diagnosis in such a large percentage of cases

I cannot affirm. It seems improbable, yet it is more improbable that success should follow an excision practised upon a chancre several days old with the inguinal glands already involved, and, as has been claimed, that failure should occur in cases like those I have narrated at the beginning of this article.

MEDIATE CONTAGION OF CHANCRON.

The mediate contagion of true syphilis is notoriously not impossible, several authentic instances of it being recorded. I do not remember to have seen the report of any case of the mediate contagion of chancroid, and therefore bring forward the following:

CASE VI.—X. aged 20, visited me in August, 1883, with an ulcer upon the penis behind the corona glandis having a hard base. There was one hard gland in the groin, slightly sensitive. His history was as follows: After two months of continence he had cohabited with a woman who had formerly been syphilitic, but had remained free from symptoms for five years. This woman was the mistress of a friend.

On the morning following intercourse the patient noticed an excoriation, which, on the third day, swelled up and discharged. It was then burned by a physician, whereupon the base hardened, and the ulcer began to grow larger. I saw it on the twentieth day, when it had all the appearance of chancroid with an inflamed base.

Five days after exposure the patient had the woman examined. She was declared sound, except as to leucorrhœa. I pronounced the sore a probable chancroid, and urged a further search as to cause. The search developed the following facts: On the night before the day on which my patient had cohabited with the woman she had had intercourse with another person and had remained partly intoxicated, and lying quiet thereafter until my patient had cohabited with her. The man in question was followed up and found to have a well-marked chancroid under treatment. This sore he had possessed at the date of intercourse with the woman. My patient's ulcer healed after six weeks. No syphilis followed. The woman did not acquire any sore, nor did the man who habitually lived with her.

THE HUTCHINSONIAN TEETH.

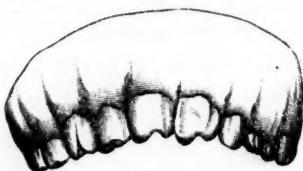
The test-teeth of inherited syphilis are the two central, permanent incisors, in the upper jaw. They are known as the Hutchinsonian teeth, after the distinguished Englishman who first accurately described them.¹ The broad, rather shallow groove in the cutting-surface is the feature which distinguishes them. These teeth are often convergent or divergent, but may be straight, and they are often narrowed on the cutting-edge, but not necessarily so.

I have here two casts of the upper set of teeth, showing the characters usually believed to indicate inherited syphilitic disease (Figs. 1 and 2). I present with them Hutchinson's original plate, and a photograph of the woman whose teeth are pictured in Fig. 2, showing the macular syphilide which was

¹ Illustrations of Clinical Surgery, London, 1876. Fascicles III., Plate XI.

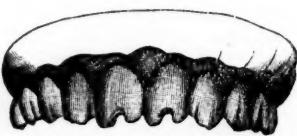
upon her when I first saw her. The patient whose teeth are represented in Fig. 1, had inherited syphilis.

FIG. 1.



The patient possessing the teeth represented in Fig. 2 showed no sign of ever having had inherited dis-

FIG. 2.



ease, and came to me with fully marked secondary syphilis, which she had acquired from her husband. I think the case is interesting, as illustrating the fact that teeth very closely, if not identically, resembling the test-teeth of Hutchinson, may be possessed by a patient who has not inherited the disease. The cases are briefly as follows :

CASE VII.—To this case belong the teeth of Fig. 1. One of the outer incisors was crowded out of line by the contraction of the jaw, and appeared behind the alveolar border. It is not represented in the cast, which was taken by the husband of the patient, a plasterer by trade.

In 1878 I first saw this patient, 14 years old, with a large gumma in the right axilla, then ten years old. Her mother, who brought her, had an old syphilitic ulcer on the leg, at the bottom of which was a necrosed portion of the tibia. The child had also a large node on the left tibia. She had strabismus and bad headache, with some scabs in the scalp. When five weeks old an eruption came out over the entire body, nose, and the feet, and she has suffered from mottled, livid, scaling spots, and rheumatic pains ever since. Her treatment had been more or less constant since birth. The child was plainly a victim of inherited disease. The mother was frankly syphilitic, and had miscarried once and produced two dead children before the birth of this child. The father was also syphilitic (ulcers and nodes).

This patient had a variety of disorders, among which was sudden blindness for half an hour at a time; but she recovered of everything, even her strabismus, under treatment; married at the age of 17; produced a healthy child; then took to drink; developed a well-marked tubercular syphilide on the arms, with ulcers on the scalp; miscarried five times in succession, and finally died.

CASE VIII.—To this case belong the teeth of Fig. 2. Mrs. X., aged 31, visited me in February, 1884,

showing flat, mottled patches of a recent papuloperythematous syphilide, covering the trunk and extremities, with a few spots on the face. She related that her husband had a sore upon his penis, and had given her a similar ulcer upon the vulva some weeks previously. The sore was well at the date of her visit to me. She showed also mucous patches in the mouth, indurated glands, fall of hair, etc., and the teeth as seen in the cast.

Her father and mother are alive and well, she says. She herself has always been healthy. She has no scars, no syphilitic countenance, no history, and no evidence of any inherited disease. She is robust and well-formed; has had five healthy children, and laughs at the idea of having suffered from any inherited malady. Actually she has recent syphilis.

In March, 1885, one year later, she returned—still under treatment at the hands of her own physician—and presenting well-marked clusters of tuberculo-squamous syphilide in patches upon various parts of the body. The photograph shows the appearance of the first eruption on the chest.

THE ADMINISTRATION OF IODIDE OF POTASSIUM IN MILK.

I wish to add a word in favor of milk as a most suitable vehicle in which to administer the iodide of potassium, notably in cases in which large quantities of the drug have to be used.

Several years ago a patient first called my attention to the fact that he could take his dose of iodide of potassium in milk without minding the taste, which otherwise was very offensive to him.

I adopted the suggestion at once, and found it of great service in many cases. Ten grains or more of the iodide in a gill of milk (cold) make a very palatable drink, and impart only a mild, metallic taste to the fluid, which most patients find not at all disagreeable. I have used this method in a routine way with the happiest result in several instances in those desperate cases in which some portion of the nervous system gives out, food is unpalatable, or cannot be taken, and the indication is, disregarding all else, to push the iodide rapidly to the point of tolerance. In such a case no time can be lost, and a fixed routine system, which shall accomplish all the needs of nourishment, as well as medication, is a very valuable factor in the treatment. I shall cite one illustrative case out of a number in which I have used the method:

CASE IX.—In the summer of 1883, a gentleman was referred to me from another city, with precocious malignant syphilis (rupial in type), and a feeble stomach. He could not digest the iodides well, as they deranged his stomach, and caused disfiguring acne, a twenty grain dose of the iodide of sodium being too much for him.

His symptoms gradually disappeared and he returned home, and for about a year did more or less well and badly, until his physician, one of the most thoroughly competent gentlemen in the profession, concluded that the antisyphilitic treatment was keeping his stomach so constantly deranged, that he was suffering more from treatment than the disease. He

therefore omitted medication for a time, and again sent the patient to New York to see me.

He came to the city, and remained in his hotel two days, not calling upon me and feeling rather better, but being much excited at night and sleepless. His only active symptom was one ulcer on the arm. On a given day at noon, while lying quietly on a lounge in his room, he got up to cross the floor. Having accomplished his object upon the other side of the room he turned to go back, but when half-way across the floor, without warning or pain, he suddenly fell in a heap upon the floor (his age was 36), without loss of consciousness, and found himself unable to get up or to speak. I saw him shortly afterward, and found him totally paralyzed upon the right side, and aphasic. He had no heart disease of any kind, and the only premonition of the attack had been a certain recurring numbness of the fingers and toes of the *left* side during each of several days before the attack. I procured a day and night nurse and ordered quiet, the cessation of all habitual food, drink, and medicine, and instructed the nurses to give him each hour, night and day, ten grains of the iodide of potassium in a claret glass of milk. He took it all, nearly three quarts of milk and 240 grains of the iodide of potassium in the first twenty-four hours. A laxative was the only other thing allowed. Increased the daily dose two drachms each second day, and after a week employed also inunctions of mercurial ointment which I pushed rapidly until the gums were mildly touched.

During the second week his daily dose reached $\frac{1}{2}$ ss of the iodide. He took no food whatsoever except the milk in which his medicine was given, and he took also an occasional laxative. His tongue cleared, the acne disappeared from his face, early in the second week he began to move his arm and leg spontaneously. Electricity and massage were now added, and in one month from date of the attack he left the city walking with a cane and dragging his foot slightly, but talking about as naturally as ever, and looking exceedingly well. The daily dose was then ten drachms taken in four separate portions, for as he got better I gave up the hourly medications, and allowed him to eat.

The patient is still under observation, doing well, taking ten drachms of the iodide a day which he has been continuing for several months, and promising nearly, if not quite, a perfect recovery.

1 PARK AVENUE, NEW YORK, April 14, 1885.

COCAINE IN DIPHTHERIA.

BY HOWARD A. KELLY, M.D.,
OF PHILADELPHIA.

THE following results, which I have obtained from the use of cocaine in diphtheria and diphtheritic sore-throat, are uniform and remarkable:

CASE I.—Jan. 21st, Emily C., age 11, complained of feverishness for two days, and for one day of sore-throat. She has anorexia and slight prostration. The fauces are red and engorged; the tonsils enlarged, nearly touching; they are both covered with a thick, pultaceous, gray mass. A diaphoretic mixture was given, and a four per cent. solution of hy-

drochlorate of cocaine applied to the throat every two hours. The false membrane began to melt immediately, and in five days she was well, and the throat normal.

CASE II.—George T., age 13, has had a headache for several days. This morning his throat began to pain him, and in the afternoon he was feverish. Both tonsils are enlarged and red; on the right tonsil is an elongated, oval patch of ulceration, one-half inch long.

Cocaine was applied as in preceding case, and in two days the throat was well; and the prostration, which had been marked, disappeared gradually after.

CASE III.—Mary F., age 19, hump-back, has felt weak and prostrate for two days. She has a rapid, feeble pulse; fever, and an enlarged tender gland under the right ear and sore-throat. The pharynx is engorged, and of an angry-red color. The tonsils are both enlarged, and on the right tonsil is an oval patch of ulceration a half inch long.

Cocaine, applied as in the preceding cases, cured the inflammation in twenty-four hours, and completely removed all trace of ulceration, except a thin, crescentic ring, which formed the anterior border of the ulcer.

CASE IV.—Mr. O'C., a very intelligent druggist, came into my office, a few evenings since, looking very wretched with a stiff neck, and in a hoarse voice informed me he was "all broken-up." The pulse was quickened; temperature 102° ; the pharynx and fauces very red. On the left tonsil was an elongated, whitish ulcer, half an inch in length. The secretions were constantly accumulating in the throat, and he suffered severe pain in clearing it. Cocaine, used as in the other cases, relieved the pain in hawking, cured the ulcer in one day, and on the second day the patient was feeling perfectly well.

In each of these cases, except the third, in which cocaine alone was used, some constitutional measures were employed, as I have found that they always add greatly to the patient's comfort, although apparently exerting no control over the duration of the disease. For this purpose I give morphine in small doses, or bromide of potassium, or nitrate of potassium, with sweet spirits of nitre, concentrated tincture of gel-simum, or liquor potassæ citratis.

Dr. Schools, of this city, informs me that he has had a similar experience with the drug in a case like the first I have detailed.

In the so-called cases of diphtheritic sore-throat with erosion I feel confident the cocaine is of signal value.

MEDICAL PROGRESS.

RHEUMATIC PHLEBITIS.—DR. LETULLE, in the *Gazette Médicale de Paris*, reaches the following conclusion relative to rheumatic phlebitis:

1. Rheumatic phlebitis is one of the rare complications of acute articular rheumatism.
2. It affects by preference the veins of the lower extremities, and more particularly those of the left leg.
3. Stasis of the blood (the same as for phlegmasia alba dolens) seems to be one of the most active of de-

termining conditions which favor the formation of phlebitic clots.

4. The coexistence of cardiac complications and anterior pleuro-pulmonary disease (conditions often met) seems to play an important part, though secondary in increasing the intravenous blood-pressure.

5. The pathogenic influence of primitive inflammatory lesions (antecedent endophlebitis) appears disputable.—*Revue Médicale*, March 14, 1885.

HYDROCHLORATE OF COCAINE AS AN ADJUVANT TO CATHETERIZATION.—DR. DE LARABRIE, in the *Gazette Médicale de Nantes* of March 9, 1885, says: Since the discovery of the anæsthetic effects of hydrochlorate of cocaine upon the ocular conjunctiva, its field of usefulness has constantly extended. Besides the well-known effects upon the pharynx, stomach, and vagina, it also can be used with great advantage in operations upon the urethra. Knopp, by experimentations upon animals, first demonstrated this fact. The following clinical evidence justifies the conclusions reached, and gives foundation, in fact, to recommend its use in urethral surgery. The case is the following: A young man, afflicted from infancy with nocturnal incontinence of urine to the present time, has resisted all means employed to remedy the condition. Galvanization was at last resorted to according to Guyon's method.

The patient was constitutionally weak, and presented at the same time some constriction of the urethra along with unusual sensitiveness of the canal. When catheterization was practised the first time, the procedure was accompanied by extreme pain, which seemed greatest when the instrument reached that portion of the urethra midway between the glans penis and the scrotum. Urethral spasm also was produced, and was followed by oozing of blood for twenty-four hours. Urination during the following days was frequent and painful.

All efforts at treatment were alike painful, and finally resort was had to cocaine, and previous to each attempt to introduce the sound a one per cent. solution of the drug was injected into the urethra.

On first trial the injection was repeated after a few minutes, and the sound was tolerated without the least pain. There existed, in fact, absolute insensibility, which lasted for about two minutes, a short but sufficient time to permit the introduction of the sound and exactly locate the constricted portion of the urethra. Since this time each application of electricity has been preceded by injection of cocaine, and subsequently the bladder has been entered without pain.

It is worthy of remark that while a five per cent. solution is required to anæsthetize the conjunctiva, and though Schrotter, of Vienna, uses a twenty per cent. solution for operations upon the larynx, yet for the urethra a one per cent. solution is sufficient to produce complete anæsthesia.

IODOFORM DRESSINGS.—DR. V. MOSETIG-MOORHOF, in a paper read at the International Congress at Copenhagen, on the efficiency of iodoform dressings, reaches the following conclusions:

1. Iodoform is applicable as an antiseptic and aseptic dressing to all wounds, whether old or recent, deep or superficial. It is specially to be recommended in those wounds which, for any reason, cannot be carefully kept

under observation, or in which the extensive apparatus necessary for antiseptic precautions is wanting.

2. Pure iodoform is also applicable to all such wounds as will heal by first intention. For this purpose the fine powder, lightly strewn over the wound, is the best form for use, and will exercise no opposition to the prompt healing of the wound.

3. Iodoform is specially to be recommended in the treatment of fungous or recent wounds attributable to local tuberculosis, and for such purposes far excels all other antiseptics hitherto recommended.

4. The application of the iodoform dressing is simple and cheap. Within reasonable limits it is not as dangerous as are some methods of antiseptic dressing.—*Medizinische Chirurg. Centralbl.*, March 27, 1885.

ANTISEPTIC TREATMENT OF ERYSPIELAS.—M. VERNEUIL, in a communication to the Académie de Médecine de Paris, after giving statistics in proof of the efficiency of the antiseptic treatment of erysipelas, concludes his observations as follows:

1. Erysipelas is an infectious, contagious, and auto-inoculable disease, which, for various reasons, it will be difficult for a long time to suppress.

2. In great centres erysipelas, essentially endemic, is propagated from two sources—externally from the city, internally from the hospital—which reciprocally infect each other.

3. It is possible to prevent, to a great extent, the appearance and extension of the disease by precautions against auto-inoculation, by antiseptic dressings, by isolation when it is possible; and, in default of this, by creating about the patient a circumscribed antiseptic atmosphere.

4. The diminution of erysipelas in the surgical wards not only has for its effect the sanitation of these wards, but conduces to an improved sanitary condition of the entire hospital, and of the quarters tributary to the hospital, as is shown by the considerable diminution of erysipelatous admissions from without.

5. If the prophylactic and curative resources against erysipelas, of which science has proved the efficiency, are rigorously and generally applied in city and hospitals, it is possible that erysipelas may become as rare as pyæmia, and, perhaps, disappear as completely as hospital gangrene.—*L'Abeille Médicale*, March 2, 1885.

PSEUDO-PARALYSIS PRODUCED BY CARBONIC OXIDE GAS.—At a meeting of the Royal Academy of Medicine of Torino, lately held, Professor Morselli presented a communication from DR. GIUSEPPE MUSSO, on a new form of general pseudo-paralysis by slow poisoning by carbonic oxide.

All the forms of pseudo-paralysis hitherto recognized are due to the effect of alcohol, lead, or syphilis, but Dr. Musso now shows that general pseudo-paralysis may be developed by the incomplete combustion of carbonaceous substances in confined and ill-ventilated apartments.

At the same meeting of the Society was reported a case in which trephining was performed on January 1, 1885, for epilepsy occasioned by a depression of the skull, produced four years ago by a blow. Cure resulted in a few days, and the general, as well as the mental, condition of the patient improved noticeably

after the operation.—*Gazzetta degli Ospitali*, March 15, 1885.

OSSEOUS AND ARTICULAR TUBERCULOSIS.—DR. FERRARI, in a recent study of osseous and articular tuberculosis, has reached the following conclusions as to this special manifestation of tubercular disease:

1. The slowly developing fungous processes of the bones and articulations—generally designated as white swellings, etc., are manifestations of tubercular periositis, osteitis, osteomyelitis, or synovitis.

2. Tuberculosis of the bones is manifested under two different forms: *a*, the circumscribed, *b*, the infiltrated, variety.

3. Both these forms are distinct from tubercular osteitis and osteomyelitis.

4. In the infiltrated variety, designated *acute tubercular osteitis*, the rapid destruction of the osseous tissue is histologically distinct from the rapid development of tubercular follicles which, without passing through the different stages of the development of tubercle, undergo a rapid, cheesy degeneration.

5. In fungous synovitis tuberculosis is manifested under two forms, one of which is distinct from the development of tubercular follicles; the other from the diffuse infiltration of lymphoid cells, in the midst of which giant cells appear.

6. In the fungous, osseous, or synovial growth the specific bacilli tuberculosis are frequently found, but not in such abundance as in other parts affected with tubercular disease.—*Gazzetta degli Ospitali*, March 22, 1885.

THE TRANSPLANTATION OF MUSCLE AND REGENERATION OF MUSCULAR FIBRE.—DR. EDUARDO SALVIA, in an experimental study upon the transplantation of muscle, and the regeneration of muscular fibre, sums up the results obtained as follows:

1. It is possible to transplant a portion of the muscular tissue of one animal into that of another, difference of species having no effect upon the result.

2. The transplanted portion of muscle may unite completely with the muscle with which it is brought into relation by first intention. To obtain this result, it is necessary that the transplanted muscle completely fills up the void made by the retraction of the excised muscle, and that the operation be conducted under strictly antiseptic conditions.

3. The union between the transplanted muscle and that of the animal upon which the operation is performed takes place from the formation of new muscular fibre, which is produced without leaving trace of the original points of separation.

4. The muscular fibre which is introduced gradually loses its own special anatomical peculiarities, and acquires those of the living animal, to the degree that after a time the most careful microscopic examination is unable to detect a difference between the original and acquired muscular tissue.

5. The function of the muscle after its introduction in a relatively short period is perfectly restored, without the slightest tendency to weakness or stiffness.—*Gazzetta degli Ospitali*, March 22, 1885.

NEPHRECTOMY FOR ENCEPHALOID TUMOR OF THE KIDNEY.—At a meeting of the Académie de Médecine

de Paris, held March 30, 1885, M. PÉAN presented a patient upon whom he had performed the operation of nephrectomy for encephaloid disease of the kidney. The patient, previous to the operation, was cachectic in the extreme, and, though advised against undergoing operation, insisted upon its performance.

M. Péan proceeded as follows: The tumor was exposed by an incision in the median line, extending from the epigastrium to the pubis. The mesentery was incised, and the numerous dilated veins treated by compression.

The tumor was then found to be surrounded by a capsule, which was, to a certain extent, removable by the fingers. Before continuing the removal of the capsule further, the tumor was taken away by degrees in small portions, partially with the fingers and partially with a spatula. This necessitated the compression of numerous arterial and venous trunks.

The operation was continued till the whole mass was removed. The diseased tissue was darkish green in color, ecchymosed in spots, and contained throughout its mass granular calcareous nodules. It was adherent, moreover, to portions of the small intestine—the mesentery, and to some of the vascular trunks—to separate it from which required great care.

Sufficient progress had now been made to discover that the growth had its origin in the right kidney, of which the pelvis and the ureters were in a state of fatty degeneration. The kidney and its appendages were then removed, the vessels and ureters having been cut between two ligatures.

The mesentery was then united by three ligatures, which were left in the abdominal cavity. The operation lasted one hour. The tumor weighed more than twelve pounds. In three weeks the woman was convalescent.

A microscopic examination, by M. Robin, showed the tumor to be an epithelioma of the kidney.—*L'Union Médicale*, April 2, 1885.

NAPHTHALIN IN THE INTESTINAL CATARRH OF CHILDREN.—DR. PH. PAULI, in the *Berliner klin. Wochenschr.*, of March 9, 1885, publishes an account of his clinical observations concerning the use of naphthalin in the intestinal catarrh of children.

The ages of the children—a history of whose cases is given—vary from one and a half to five years, and in all the drug seems to have been very successfully used.

The quantity of naphthalin administered varied with the age of the patient, and ranged from a grain and a half to fifteen grains daily. In one case, in which the remedy seemed not so prompt as in the others, increasing the dose until the feces had a strong odor of naphthalin had the desired effect. Dr. Pauli remarks that, for prompt action, doses that can be so recognized are necessary.

In the cases treated, with one exception, there was no return of the disease, and in this instance it was insignificant. In two cases of the diarrhoea of phthisis the administration of naphthalin had the effect of diminishing the number of stools, but, on discontinuing the remedy, the diarrhoea returned and persisted.

NEPHRECTOMY FOR ENCEPHALOID TUMOR OF THE KIDNEY.—At a meeting of the Académie de Médecine

N. 55, publishes the results obtained by him in the treatment of serious forms of intermittent fever by the association of the bromohydrate of quinine and valerianate of caffeine. He claims, as a result of comparative trials of the sulphate and bromohydrate of quinine, the superiority of the latter in the following respects:

- a. A greater activity in smaller doses.
- b. A gradual sedative action upon the nervous system.
- c. The power of abating, and finally of removing, all tendency to vomiting, — a property worthy of special consideration.
- d. In the ease with which it gains mastery over the malarial infection.
- e. In that the ill-effects of the drug are less marked, or indeed imperceptible.
- f. In that it does not irritate the stomach, or produce diarrhoea.
- g. In that hypodermatic injections are less frequently required.
- h. In that relapses and returns of the fever are less frequent under its use.
- i. Because, by associating the bromohydrate of quinia and the valerianate of caffeine (fifteen grains of the former to eight of the latter), many quotidian forms of the disease may be subdued which do not yield to the sulphate in much larger doses.
- j. Because the comparative cheapness of these drugs renders their employment less onerous to patients in moderate circumstances.

OVARIOTOMY.—PROF. GIOVANNI CALDERINI recently performed two difficult operations for ovariotomy at the Obstetrical and Gynecological Institute of Parma. In the first case there was an enormous left tubo-ovarian cyst, which presented extensive peritoneal adhesions.

In the second a bilateral ovariotomy was performed. The left ovary contained a cyst largely adherent to the peritoneum, parietes, and pelvis. The right ovary also had undergone cystic degeneration, and was the size of a hen's egg. Notwithstanding the difficulty and extent of the operation in each case, they were successfully concluded, and both patients are convalescent.—*Gazzetta degli Ospitali*, March 25, 1885.

NEPHRECTOMY.—DR. VINCENZO DATTILO, on the 8th of March, 1885, performed a difficult operation of nephrectomy for suppurative pyelo-nephritis. The walls of the cyst could not be removed, owing to extensive adhesions to the lumbar muscles, the diaphragm, and peritoneum. They were accordingly secured to the edges of the external wound by interrupted sutures. The cyst was previously evacuated eight times with Potin's apparatus, four pints of a purulent fluid being obtained at each evacuation. The operation, which was preceded by a ninth puncture with Potin's aspirator, and by free exsection of the twelfth rib, lasted forty minutes, and was conducted under strict antiseptic precautions. The highest temperature recorded subsequent to the operation was 100.4° F. The patient is rapidly recovering.—*Gazzetta degli Ospitali*, March 25, 1885.

RESECTION AND SUTURE OF THE MEDIAN NERVE.—M. SURMAY has recently published an interesting case

of resection and suture of the median nerve, in which immediate union resulted in the reestablishment of the function of the nerve, except sensibility to pain and temperature. From the result he draws the following conclusions.

1. That simple hypertrophy of the neurilemmar tissue between the primitive nerve fascicles may determine the abolition of the functions of the nerve.
2. That after resection the union of the two ends of the nerve may be followed by immediate reunion.
3. That this reunion may be accompanied by the immediate reestablishment of the functions of the nerve.
4. That in the restoration of the function of the nerve general sensibility, tactile sensibility, and sensibility to pain and temperature do not return simultaneously, but in the following order: sense of touch, general sensibility, ability to appreciate pain, and, finally, to distinguish temperature.—*Revue Thérapeutique*, April 1, 1885.

CHOLECYSTOTOMY IN THE TREATMENT OF BILIARY CALCULI.—PROF. JULES BŒCKEL, in a paper read before the French Surgical Congress, held April 6 to 12, 1885, reaches the following conclusions as to cholecystotomy as a method of treatment of biliary calculi:

Cholecystotomy is or is not grave as depends upon (A) the presence or (B) absence of biliary fistulae.

A I. In the first case (existence of a fistula having demonstrated or given cause to suspect the presence of one or several calculi), operative interference is demanded.

II. Although cure is sometimes spontaneously effected, there is great advantage in operating opportunely.

III. Early intervention assures and hastens the cure by preventing accidents due to incessant draining of the bile.

IV. The operation is one of great simplicity and remarkable benignity, owing to the adhesions which unite the gall-bladder to the abdominal wall; even when it is necessary to open the peritoneum, cholecystotomy, practised under these conditions, may be considered harmless when done under antiseptic precautions.

B I. In the second case (absence of fistula and adhesions), the operation is much graver, and its indications are much more difficult to grasp.

II. Primarily, the diagnosis must be established and the cause of obstruction fully ascertained, in order to avoid an operation of doubtful utility.

III. When the history, progress of the disease, examination of the patient, and, above all, the presence of a biliary tumor, and exploratory puncture, reveal the presence of biliary calculi, cholecystotomy, opportunely performed, seems to be indicated.

IV. When the diagnosis is well established the operation should be done as early as possible, to obviate the serious, or even fatal, complications which may result from delay.

V. In all other cases the operation is in itself too grave, and its results too uncertain to justify its performance.

VI. At present our knowledge is not sufficiently definite to decide as to the relative merits of cholecystotomy or cholecystectomy. To solve the problem, additional data must be collected.

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SATURDAY, APRIL 25, 1885.

NEPHROLITHOTOMY.

MR. CHIENE, of Edinburgh, narrates, in the *British Medical Journal* for February 7, 1885, a successful removal of a calculus, weighing forty-eight grains, from the otherwise healthy kidney of a man twenty-nine years of age. The chief symptoms were long standing, intermittent, and severe pain in the loin, and bloody urine. As soon as the kidney was reached by the ordinary incision, an elevation was detected in the substance of its lower half, which proved, on exploration with a needle, to be a stone. The parenchyma of the organ was scratched through with the finger-nail until the concretion was reached, the wound enlarged with dressing forceps, and extraction effected. There was considerable oozing of blood; two drainage tubes were inserted, and antiseptic dressings were applied. At the expiration of rather more than three months, the relief was complete.

DR. SYMONDS and MR. HENRY MORRIS have each recorded in the *Lancet* for March 7, 1885, an equally gratifying result; and on last Wednesday, at the meeting of the American Surgical Association, Dr. Tiffany, of Baltimore, read a paper on renal lithotomy, in which he gave the details of a successful removal of a stone weighing five hundred and fifty-six grains, it being the largest on record.

In 1869 Mr. Annandale advocated nephrolithotomy. Simon, in 1871, suggested acupuncture of the exposed organ, with a view to detect the concretion; and Dr. Gunn, of Chicago, and Mr. Durham, in 1872, were the first to cut down upon the kidney in the expectation of finding a stone. It was, however, reserved for Mr. Henry Morris, in 1880, at the

suggestion of Dr. Coupland, to perform the first formal nephrolithotomy, and, in the five years which have elapsed since its successful introduction, it has established for itself the reputation of being an eminently safe and rational procedure.

In connection with the cases of Chiene, Symonds, Morris, and Tiffany, and an able and instructive address on "Some Points in the Surgery of the Kidneys," recently delivered by MR. MORRIS at the Medical Society of London, and published in the *British Medical Journal* for February 14, 1885, we propose to discuss the operation of nephrolithotomy, and briefly compare its results with those attained by nephrectomy for calculus alone, and with those secured by nephrectomy and nephrotomy for calculus associated with other lesions.

At the outset it should be stated that by nephrolithotomy is meant, as declared by Morris in his original paper on the operation, which may be found in the *Transactions of the Clinical Society of London*, vol. xiv., incision of the kidney simply and solely for the removal of a renal calculus, the organ not being dilated by pus or urine. For these reasons, we omit the cases of Haward, Golding-Bird, and Jones, of Manchester, which are usually referred to as examples of the procedure, as pus was present in all. The statistics are derived from a paper read at the recent meeting of the American Surgical Association by Dr. S. W. Gross, many having been gleaned by him from private sources of information.

Nephrolithotomy has been resorted to in 21 cases, the operators having been Thornton in 3, Morris and Beck, each in 2, and Butlin, Bardenheuer, May, Howse, Hill, Symonds, Anderson, Godlee, Elder, Cullingworth, Pepper, Chiene, Rouse, and Tiffany, each in 1. Of the entire number, 2, or 9.52 per cent., died; the patient of Cullingworth from the blocking of the opposite ureter by a stone near its vesical orifice, while the patient of Pepper expired suddenly, some days after, from causes which were not connected with the operation. Thornton's cases were by the combined ventral and lumbar incision, the kidney having been reached in the remainder through the loin. In the cases of Butlin, Anderson, and Cullingworth, the stone was removed through an incision in the pelvis of the kidney; in the others, it was extracted through an opening in the substance of the organ. In the case of Bennett May, the calculus weighed nearly an ounce, and its extraction was followed by profuse venous bleeding, which was, however, speedily arrested by pressure. In only two other instances was this accident met with, but the loss of blood was readily and easily controlled.

From existing experience it appears that the extraction of a calculus from an otherwise healthy kidney is an operation almost without danger to life. All of the recoveries were prompt and perfect, except

in the first case of Morris, in which a suppurating sinus still persists five years subsequently. In three of the cases, the stone was removed through the pelvis of the kidney, on which account Mr. Anderson suggests the term pyelolithotomy, to distinguish the operation from the ordinary one in which the concretion is removed through an opening in the parenchyma of the organ. This, however, is an unnecessary complication of nomenclature, and no special stress need be placed upon any supposed advantages to be derived from the site of the opening, as the surgeon will cut or scrape through the tissues which cover the stone. Under no circumstances should any but the lumbar incision be resorted to, unless there be doubt as to which kidney is involved. Under these circumstances, laparotomy is proper, and the kidney and ureter should be examined on both sides. Had Mr. Cullingworth suspected the presence of a stone in the opposite ureter, an exploratory median incision and intraperitoneal ureterotomy would probably have saved his patient.

With such an excellent record, it is remarkable that the operation has not been more frequently resorted to, and it is odd that only two cases have occurred outside of Great Britain. The uncertainty of the diagnosis in the earlier stages of renal calculus has, however, probably deterred many surgeons from performing it, since the symptoms are almost identical with those met with in commencing strumous kidney, and with those observed in persons with an abnormally acid urine, or of a gouty tendency, or who lead sedentary and indulgent lives. Hence, Mr. Morris is emphatic in stating that before a surgical exploration of the kidney, with a view to nephrolithotomy, is undertaken, symptoms which are regarded as characteristic of renal calculus shall have existed for some months, and still persist; and, secondly, that these symptoms have not yielded to ordinary treatment. As a rule, recurring attacks of renal colic, the presence of blood or pus in the urine, frequency of micturition, and the absence of prostatic or vesical lesions which can explain these phenomena, are held to be sufficiently characteristic symptoms. Experience has, however, demonstrated that they are not positively characteristic, since surgical exploration of the kidney has frequently failed to detect a calculus when these signs were pronounced.

With these symptoms before him, however, the surgeon is justified in making an exploratory operation. If a calculus be removed, the integrity of the organ is saved, and advancing suppuration prevented. If, on the other hand, a stone is not found, our present knowledge warrants us in stating that no danger will have been incurred. Thus, of 22 exploratory operations, of which 3 were done by Marcus Beck, 2 each by Morris, Lucas, and Annandale, and 1 each

by Gunn, Durham, Lente, Golding-Bird, Barker, Barbour, Norton, Anderson, Fowler, Powell, Thornton, Hulke, and Lawson, all recovered, the kidney having been actually incised in three. More than this, the mere digital exploration of the organ has in some instances been followed by prolonged relief: first, by the securing of a mobile kidney in its proper place through the contraction which followed cicatrization; secondly, by causing cessation of the pain and renal irritation through division and stretching of the nerves of the lumbar region; thirdly, by taking off tension from a perinephritic inflammation; and, fourthly, by giving vent to a little pus after puncturing a scrofulous kidney.

In some of the failures, a stone was doubtless overlooked. Even when supplemented by acupuncture, the detection of a calculus is not always easy, as is shown by a case in which Mr. Morris recently removed an otherwise healthy kidney containing a concretion, which the repeated use of the needle had failed to discover. Hence, he concludes, and as we think very justly, that ordinary exploration with the finger and needle should not be considered a complete exploration, but that the kidney should be incised, after the failure of these measures, in order that its pelvis and calices may be thoroughly examined with the finger. This procedure will doubtless add to the risks of the procedure, and, it may be, subject the patient to the annoyance of a sinus or a urinary fistula, a contingency which is to be feared, if we may base an opinion upon the frequency of the formation of such a sinus or fistula after nephrotomy for calculous pyonephrosis, ordinary and strumous suppuration, and hydronephrosis, as they are met with in one-third of the recoveries.

Nephrectomy for calculus uncomplicated by other lesions has been done by Czerny, Kosinski, and Morris. Two of the operations were by the lumbar incision, and one by the ventral incision. Despite the fact that the patients recovered, the organ should never be removed for this condition. It may happen, however, that, even after incision, a stone cannot be detected, and that the patient's sufferings demand that extirpation be resorted to. Under these circumstances, a stone may be present, but the surgeon has the satisfaction of knowing that a useful organ was not sacrificed until all the means for the detection of the stone had been employed and failed.

That nephrolithotomy is a most judicious procedure in the early stage of renal calculus, is shown not only by the favorable results of the operation, but by a comparison with other operations performed after the concretion has given rise to more or less advanced disorganization of the kidney. Thus, of 20 nephrotomies for calculous pyonephrosis 9, or 45 per cent., were fatal, while of 23 nephrectomies for a similar condition, 10, or 43.47 per cent.,

perished. For calculous hydronephrosis, 4 nephrectomies indicate 1 death. These facts are suggestive, since they indicate the great necessity of framing an accurate diagnosis of a renal concretion before it has occasioned destructive changes which are liable to terminate in the death of the patient, whether he be abandoned to nature's efforts, or be afforded a chance by a resort to the knife. They also show the great importance of increasing our knowledge of the symptoms of renal calculus, in order that its early removal may be more frequently practised.

ANTIPYRETICS IN PUPERAL SEPTICÆMIA.

One of the most important and frequent indications in the treatment of puerperal septicæmia is the reduction of the high temperature. But there is a difference of opinion as to the best means for causing this reduction. Thus Dr. Charles, of Liege, in the *Journal d' Accouchemens*, February 28, recommends thirty-four grains of quinine and one-tenth of a grain of aconitum made into twenty pills, and if a patient's temperature be 102° F., or more, gives one of these pills every hour, or once every two or three hours, as the temperature may require. The quinine treatment is probably that which is followed by most practitioners, and a preparation of aconite may be added, though probably few use aconitum, because of the uncertain strength of this form of the drug. Siredey, though advising quinine in that form, of septicæmia which he calls lymphoperitonitis, claiming that the medicine is marvellously appropriate to the morbid state, being antipyretic, sedative, and anti-septic, prefers in infectious phlebitis, alcohol associated with extract of cinchona. He gives about two ounces, of alcohol in the twenty-four hours. It certainly seems to us better in this disease, if alcohol is to be used, to give it thus in a known quantity, than to give it as is usually done in the form of whiskey or brandy. Moreover, when a definite quantity of alcohol is directed, the nurse will be very careful not to give more or less than the amount prescribed, and thus a blunder that may cause death be prevented.

Dr. Barbier, of the Maternity of Liege, after trying antipyrrin in a case of puerperal metritis associated with phlegmon of the iliac fossa, states that it caused a reduction of temperature when aconitum, quinine, sodium salicylate, muriate of quinine hypodermatically, and carbolic acid had failed. Barbier, referring to Henocque's assertion that antipyrrin acts upon the bloodvessels and causes contraction of the capillaries, suggests that it may prevent absorption of septic matter by causing contraction of the uterine vessels.

A case of phlebitic puerperal septicæmia now under treatment confirms the statement as to the very prompt reduction of temperature caused by an-

tipyrin. A single dose of nine to fifteen grains will cause within two hours a reduction of temperature of between 2° and 3° F. Very profuse sweating follows the administration of the remedy, and the patient is somewhat prostrated. Unfortunately, the temperature usually begins to rise in about three hours.

REMOVAL OF TUMORS OF THE BLADDER.

IN *The Medical Record* for March 15th may be found the results of 100 operations for the removal of neoplasms of the bladder of both sexes, collated by DR. STEIN, of which 54 occurred in males and 46 in females. In view of the recent impetus given by Sir Henry Thompson and Mr. Whitehead to the surgery of vesical neoplasms, these statistics are of more than ordinary interest.

The operations on males include external perineal urethrotomy, perineal cystotomy, hypogastric cystotomy, combined hypogastric and perineal cystotomy, and combined epicystotomy and perineal urethrotomy. Of the 31 external perineal urethrotomies 14 terminated fatally. Of the 17 recoveries, in 5 the growth was only partially removed, so that permanent relief was not to be expected; in some cases the relief was decided, but temporary; while in others the reports were too recent to determine the final result. Of the 10 perineal cystotomies, of which the majority were by the lateral method, 6 recovered, 3 died, and 1 was of recent date. Of the 11 epicystotomies, 2 recovered and 9 died, and further data are required in the recoveries to admit of any positive statement as to the ultimate issue. In at least five of the cases the growths were malignant, and a decided amelioration of the symptoms was noted in four. One combined suprapubic cystotomy and lateral perineal cystotomy recovered, while one combined epicystotomy and median urethrotomy perished.

Of the 46 operations on females 37 were by urethral dilatation, 8 by incision of the urethra, or by colpocystotomy, and 1 by resection of the bladder. Of the 37 in which the growths were removed through the urethra, 24 recovered, 3 were much improved, and 10 died. Of the 8 cutting operations, 5 recovered, and 3 died. The operation of resection of nearly the entire bladder for sarcoma, done by Sonnenberg, was doing well nearly four weeks subsequently.

In his comments upon these several procedures Dr. Stein very justly concludes that each will have to rest upon its own merits, and that a disposition to routine practice is manifested, especially in favor of median urethrotomy. As a result of this practice, not a few sessile neoplasms, particularly when seated at other points than the lower fundus, have been incompletely removed, and thus served to swell the list of deaths. Hence, we agree with him in advising

that in all cases an exploratory median cystotomy in the male, or dilatation of the urethra in the female, should be resorted to, when, if accessible and removable, the growth can be gotten rid of. If, on the other hand, it is inaccessible or too broadly attached, the bladder can be opened above the pubes, and removal be effected. The recorded failures should not militate against its performance, since in nearly one-half of the cases the disease was malignant, while in others the operation was too long deferred.

GENERAL GRANT'S CASE.

SINCE Sunday, April 12th, General Grant's condition has undergone uninterrupted improvement. He has been free from pain, has eaten with relish, and has slept naturally. His strength has so far returned that he has left his room, has joined the family at table, and has driven in Central Park. This great improvement has, apparently, coincided with a partial or complete abandonment of the use of morphine, digitalis, and alcohol, which had become no longer needed; but it cannot be safely taken to indicate an advance toward a certain, or even probable, recovery. If the disease is epithelioma, recovery is so improbable that it cannot be predicted or even anticipated; it can only be recognized after it has taken place.

But, is it epithelioma? Of that the physicians in charge are best able to judge, although others, knowing the recognized difficulty and uncertainty of a diagnosis in any such case, may, properly, entertain a doubt. It is highly improbable that individual difference of opinion should not exist among four consultants;—indeed, if there were no doubt, why should there be a consultation? Moreover a sentence in a late bulletin, significant in what it leaves unsaid rather than in what it says, seems to point to differences in this case. “The physicians in attendance are, and have been, in entire agreement concerning the management of this case”—not the diagnosis, only the “management,” is what the bulletin says; and yet the phrase was plainly written to meet the criticisms of the diagnosis, with which the daily press has of late been filled. A positive diagnosis has been published by only two of the professional attendants, and to those who are acquainted with the large experience, calm judgment, and wise prudence of the others, it would not be surprising if it should appear that they had refused to say that there could be no doubt concerning it.

It is particularly unfortunate, under the present circumstances, that the microscopical examination was not made by a pathologist of wide reputation. It is not to the discredit of the gentleman who did make it that he is not widely known, for he has

been but a short time in the ranks of the profession. The demonstration may have been complete, but in such an important case, if an opinion on the microscopic appearances of the diseased tissue was to be published, it would have been better if the report had been made by such recognized authority as would have carried conviction with it to the mind of every one.

The disease appears to have made no progress locally; the slough on the back of the pharynx has in great part fallen, leaving a slightly elevated surface; the right half of the soft palate is destroyed, and the lump behind the angle of the jaw is larger and more diffuse.

CARE OF POOR WOMEN DURING THE LYING-IN PERIOD.

DR. JOHN P. GRAY, the distinguished Superintendent of the Utica Institution for the Insane, has recently delivered a very interesting address upon insanity, and some of the means for its prevention. Among these he mentions want of proper care during maternity, especially during the lying-in period. He takes the just ground that a woman for a month after labor should be free from toil, worry, and anxiety, and that she should have suitable food. In order to secure these most desirable ends for poor women, he suggests the employment of women of the same social class to do the housework, and to be paid for it by an association. This association should be under the care of a physician, and, of course, must depend upon private beneficence for its support. In support of his views he observes: “If women knew they would have all needed care, not in a hospital with its necessary publicity and separation from home, but in their own homes and among their families, and without the notoriety of their condition, what a burden would be lifted, what health saved, and what insanity prevented.”

Dr. Gray has had most favorable and extensive opportunities for studying the causes of insanity, and whatever he may say upon the subject is entitled to consideration. Certainly the observation of every practitioner of obstetrics among the poor, will offer instances confirming Dr. Gray's views as to insanity often resulting from neglect and want of proper care after labor. The suggestion made for the prevention of this evil seems to us wise, just, and practicable. In all our great cities there are multitudes of mothers whose condition cries aloud for the very protection proposed. And in all our large cities too, there are men and women of wealth and generous hearts, who, if properly appealed to, would be willing to give liberally for the purpose indicated. We hope the day will soon come when such associations as Dr. Gray proposes will be in active operation wherever needed.

SOCIETY PROCEEDINGS.

AMERICAN SURGICAL ASSOCIATION.

Sixth Annual Session held in Washington, D. C., April 21, 22, 23, 24, 1885.

(Specially reported for THE MEDICAL NEWS.)

TUESDAY, APRIL 21ST.—MORNING SESSION.

THE Sixth Annual Session of the American Surgical Association assembled in the Hall of the Army Medical Museum, at Washington, and was called to order at 11 A.M., by THE PRESIDENT, W. T. BRIGGS, M.D., of Nashville, who then delivered the

ADDRESS OF THE PRESIDENT.

After expressing his profound appreciation of the exalted honor conferred upon him by his election to the Presidency of the Association, he said :

We may safely indulge the confident expectation that this meeting will be characterized by the spirit in which the Association had its origin, and will be pervaded by the same united purpose, the same harmonious and agreeable intercourse and similar valuable work to that which has edified and instructed us in previous meetings, and which, in the brief period of its existence, has so illustrated the usefulness of the Association that its permanency as an exponent of the status of American surgery, and as a factor in the true advancement of its science and art, is fully assured.

Notwithstanding these just and bright anticipations on the threshold of this session, we feel oppressed and saddened by the notable absence of a Fellow who, when among us, stood, like Saul, "a head and shoulders taller than his brethren;" an absence which deprives us of the light of remarkable genius and learning upon our discussions, and, at the same time, bows our heads in sorrow for the loss of one whom we had come to venerate as the Nestor of American surgery. While we sat a year ago, his noble form lay prostrate, and his spirit was then near passing, though we had hope that he might be spared. To-day we realize that he whose fertile brain conceived, and whose indomitable effort brought this Association into existence, and developed it to its present proud position among the scientific bodies of the country, has gone from us forever. The death of Prof. Samuel David Gross orphaned the surgical profession of America, and removed from its ranks one who, as pathologist, surgeon, and medical philosopher, was the acknowledged peer of any one in the world. He no longer lives in the flesh, but his labors in the domain of science, for a period of nearly sixty years, has secured an immortality of fame, and his utterances and achievements will descend to further generations of the profession as a precious heritage. Though endowed with brilliant intellectual qualities, his life and example are truly great, in that he conspicuously illustrated the value and dignity of enthusiastic labor and devotion to his profession.

He was the father of this Association. It is the child of his old age, and was to him a deeply cherished offspring. He has left it to us, his Fellows and successors, to nurture and maintain in all the vigor and power with which he would have invested it. Let us then be ani-

mated by the same lofty spirit which moved him in its organization, and vow to each other, as in the Temple, that we will devote ourselves to the duty of making it as great and shining as the fame of its founder, and as enduring as the science to which he consecrated his life.

At the close of this address, the Association went into

EXECUTIVE SESSION.

The reading of the minutes of the previous session being dispensed with, the reports of the Treasurer and of the Committee on Publication were read, and the following

COMMITTEE ON NOMINATIONS

was appointed : Drs. C. T. Parkes, of Chicago; A. B. Watson, of Jersey City; E. M. Moore, of Rochester; W. F. Peck, of Davenport, Iowa; N. Senn and S. W. Gross, of Philadelphia; and N. P. Dandridge, of Cincinnati.

DR. DAVID PRINCE, of Illinois, then read a short paper on

ATMOSPHERIC PURIFICATION.

After dwelling briefly upon the importance of measures adopted to rid the air of its deleterious impurities, and recounting the more successful of the methods that have been and are now employed, the author introduced a pamphlet describing and illustrating a new device of his own invention, for atmospheric purification by the use of steam. The method he considered preferable to the use of the douche or spray, in that it acted upon a larger scale, and he thought it an important adjuvant to other prophylactic measures.

The report of the Committee on

RESECTIONS OF THE ANKLE-JOINT

being called, Dr. P. S. Conner reported progress, and requested a continuation of the Committee until the next annual session of the Association.

The Association then adjourned until 2 P.M.

AFTERNOON SESSION.

DR. JOHN B. ROBERTS, of Philadelphia, read a contribution on

THE FIELD AND LIMITATION OF THE OPERATIVE SURGERY OF THE HUMAN BRAIN.

The study of this subject, he remarked in opening, was suggested to him by the observation, while a resident hospital surgeon, of the death of a man from a traumatic cerebral abscess, and the inactive conservative surgery which was then in vogue. "Do we," he asked, "know no better now than to allow a man to die from acute encephalitis without even an attempt at his relief?"

He then introduced nine conclusions which, he remarked, embodied his creed on the subject of traumatic brain injuries :

1. The complexus of symptoms called "compression of the brain," is not due so much to displacing pressure exerted on the brain-substance as it is to some form or degree of intracranial inflammation.

Let the profession repudiate the idea, he urged, that displacement of brain-substance is the cause of the trouble, and they will then discard many of the erroneous

theories in regard to the use of the trephine. There are no definite symptoms by which we can distinguish between an inflammation from laceration and compression of the brain-substance. It would be well if the expression, "traumatic compression of the brain," were always translated "traumatic inflammation of the brain."

2. The conversion of a closed (simple) fracture of the cranium into an open (compound) fracture by incision of the scalp is, with the improved methods of treating wounds, attended with very little increased risk to life.

In this respect, the dangers of open fractures over closed fractures of the skull do not correspond to the corresponding fractures of other bones.

3. The removal of portions of the cranium by the trephine or other cutting instruments is, if properly done, attended with but little more risk to life than amputation of a finger through the shaft of the metacarpal bone.

It remains for the opponents of trephining to show that the cause of death, when it occurs, is due to the trephine. President Briggs and some others consider the operation one of the simplest in surgery; but other authorities oppose that view. The comparison between fractures of the skull and amputation of a metacarpal bone, the speaker considered appropriate, because in each case there was exposed a small amount of cancellous bone tissue. Amputation of the finger may be followed by septicaemia and death, and so may the operation of trephining the skull, but neither is to be expected. According to Amidon, the mortality of trephining (3.6 per cent.) is less than that of amputation through the shaft of the metacarpal bone (4 to 5 per cent).

4. In the majority of cranial fractures the inner table is more extensively shattered than the outer table. The element of danger in fractures is due solely to the splintering of the internal table. Necrosis of the splintered bone fragments is looked upon by some as the element of danger, but in the opinion of the speaker necrosis is of rare occurrence, and the true element of danger is the acute encephalitis that is excited by the splintering.

5. Perforation of the cranium is to be adopted as an exploratory measure almost as often as it is demanded for therapeutic reasons.

This measure the speaker considered justifiable in all cases in which the injury was of sufficient severity to justify the belief that spiculation had occurred.

6. Drainage is more essential in wounds of the brain than in wounds of the other structures.

This method, the author believed, had been greatly neglected, for surgeons who would be loath to permit an accumulation of pus to remain for an hour after its discovery in any other part of the body, would quietly allow a case to die from an abscess in the brain without an attempt at relief by operative procedure. Several cases were reported illustrative of this proposition.

7. Many regions of the cerebral hemispheres of man may be incised and excised with comparative impunity.

The timidity of surgeons with regard to injuring the brain-substance by operative means, the speaker attributed to the prevalent ignorance on the subject of cerebral localizations. Deaths are not due to the exposure of the cerebral convolutions.

8. Accidental or operative injuries to the cerebral membranes, meningeal arteries, or venous sinuses should be treated as are similar lesions of similar structures in other localities.

Numerous cases have been reported in support of this proposition.

9. The results of the study of cerebral localization are more necessary to the conscientious surgeon than to the neurologist.

The time has come when a man, if he assume the role of a surgeon, must make the study of cerebral localizations a special feature of his education. When called upon to operate in cases of head-injury, he must in many cases be the only one to decide what shall or shall not be done.

The principles thus set down were next applied to cranial fractures, to intracranial hemorrhage, to intracranial suppuration, to epilepsy following cranial injury, to insanity following cranial injury, and to cerebral tumors.

The following are the rules adduced by the author:

A. Cranial Fractures.

Closed (Simple) Fissured Fractures.

1. Where there is no evident depression, and no brain symptoms, no operation should be made.
2. In case of no evident depression, with brain symptoms, incise the scalp and trephine.
3. With evident depression, but no brain symptoms, incise the scalp and possibly trephine.
4. With evident depression and brain symptoms, incise the scalp and trephine.

Closed (Simple) Comminuted Fractures.

5. Where there is no evident depression, and no brain symptoms, it is advised to incise the scalp and probably trephine.
6. In cases of no evident depression, with brain symptoms, incise scalp and trephine.
7. With evident depression, but no brain symptoms, incise scalp and trephine.
8. With evident depression and brain symptoms, incise scalp and trephine.

Open (Compound) Fissured Fractures.

9. In cases with no evident depression, no brain symptoms, no operation is advised, but treat the wound.
10. Cases presenting no evident depression, with brain symptoms, should be trephined.
11. With evident depression, no brain symptoms, possibly trephine.
12. With evident depression and brain symptoms, trephine.

Open (Compound) Comminuted Fractures.

13. If there is no evident depression, and no brain symptoms, it is probably proper to trephine.
14. In case of no evident depression, with brain symptoms, trephine.
15. With evident depression and no brain symptoms, trephine.
16. With evident depression and brain symptoms, trephine.

As a working rule for surgeons the speaker believed that these conclusions would be found reliable and

correct. Trehphining has become an operation of so little danger that every case of doubt should be treated by it.

B. Intracranial Hemorrhage.

Trehphine for the removal of a clot and the arrest of bleeding when the probable seat of hemorrhage is ascertainable, and the clot is believed to be a localized one. The speaker then discussed briefly the symptoms which rendered the operation advisable and those which contraindicated it.

C. Intracranial Suppuration.

Trehphine and make, if necessary, exploratory punctures in all cases of abscess. This is rendered more compulsory because of the fact that the spontaneous evacuation or other removal of an abscess in the brain practically never occurs. Early symptoms of pus mean, as a rule, "Do not operate;" later appearances of pus indicate, however, the propriety of an early operation. If the pus is not discovered beneath the dura, then incise the dura, and if the pus is not then discovered aspiration should be performed, unless the symptoms disappear upon the removal of tension by the perforation of the dura.

D. Epilepsy following Cranial Injury.

Remove a portion of the cranium in selected cases.

Abscesses are usually situated in the anterior half of the cerebrum. The symptoms indicating the propriety of trephining in these cases are, a painful or sensitive cicatrix, and symptoms indicating brain irritation in the vicinity of the scar, especially if this be in the anterior half of the cranium. The temperature test was then referred to and the statement of a modern writer that the temperature may be taken by placing a thermometer in the auditory meatus. The symptoms contraindicating operative procedure are the presence of signs indicative of inflammatory processes at other portions of the brain, the history of epilepsy or insanity in other members of the family.

In these cases, Dr. Roberts added, several months must elapse before the case can be pronounced one of failure. The operation should be done as promptly as possible.

After a brief review of the last divisions of the application, the author passed to a demonstration upon a chart of the leading cerebral localizations. The rules for these last cases were.

E. For Insanity following Cranial Injury.

Remove a portion of the cranium in selected cases.

F. For Cerebral Tumor.

If it can be localized, and if it is probably superficial, remove the bone and excise the growth, if it is found.

Dr. HUNTER MCGUIRE, of Richmond, remarked that in reviewing the paper that had just been read, he could find but two instances in which an operation was not advised. This advice, he continued, takes us back one hundred years, to the time when men used to boast of the number of holes they carried in their heads, and when surgeons boasted of the number of heads they had trephined. There are no set rules that can be laid down for the government of all cases; each case must be a law to itself. There are no two injuries of the skull that are the same any more than there are two faces exactly alike. Referring to the first proposition,

he asked how the author could account for the almost immediate appearance of symptoms of compression of the brain in so many cases. A man receives a blow upon the head. The bone is depressed, the brain is compressed, and almost immediately, within a few minutes, or even within a few seconds, symptoms of depression are manifested. Is it possible that an inflammatory exudation could have developed so rapidly? Such, to the speaker, seemed almost impossible. The author has compared the use of the trephine to the amputation of the metacarpal bone. It was either Cooper or Hunter who said that there was to the patient between the trephine and eternity a little thin sheet of paper. How the author came to the conclusion that the application of the trephine was so simple a matter the speaker could not comprehend. He asserts that a man may even be trephined and immediately go to his home. With no disrespect, the speaker wished to know to which home Dr. Roberts referred, and whether it would not, in a great many cases, be the "long home." With regard to the importance of drainage in cerebral difficulties, he agreed with Dr. Roberts. In the last case of trephining which he had performed, he had taken out a piece of the scalp of a size to correspond to the size of the trephine, in order to secure thorough drainage. He then narrated several cases in which he had made use of the trephine. In one case, in which an individual had been insane for nine years, the day following the operation he spoke of events as occurring yesterday which had occurred nine years before, and uttered the first coherent words for that period of time.

DR. MOSES GUNN, of Chicago, recalled the position he had taken in a discussion of the same ground covered by this paper three years ago, when he had advocated the early operation in cases of cranial fracture with symptoms of depression, and had endeavored to advocate the rule that in simple or closed fracture the bone should be elevated as in compound fractures, taking the ground that aseptic measures as now practised avert the danger that would otherwise exist in the conversion of a simple into a compound fracture. This rule, he thought, if properly applied could be employed not only with safety, but with benefit to the human race.

With regard to the first proposition laid down by Dr. Roberts, he agreed, and believed that in many cases the symptoms arise not from depression but from irritation and inflammation. Mere mechanical compression of the brain is not a symptom of importance. As stated by Dr. Briggs in the discussion referred to as occurring three years ago, if compression of the brain was all that is to be feared, he would never use the trephine, because the brain would soon accommodate itself to the new pressure. The danger is in the changes of nutrition that follow. He did not go so far as Dr. Roberts, however, and say that there are no such symptoms as those of compression. These symptoms, he thought, were too distinctive in their character, and came on too soon after the accident to be due to any other cause. There is then mechanical compression, and not irritation or inflammation. But that mechanical compression does not require the application of the trephine. The danger of permitting the pressure to remain is that it may become permanent and excite irritation and in-

flammation that may do injury, in giving rise to secondary symptoms.

DR. C. B. NANCREDE, of Philadelphia, agreed with the writer of the paper in many points, but differed from him in a number of others. As to the first proposition, he agreed with the previous speaker. If Dr. Roberts were to call it secondary compression he would agree with him in the conclusion: that it is due to some form of inflammation. Compression of the brain produces sudden and violent contraction of the vessels of the brain in the vicinity of the compression. It is an error to associate in our minds the dangers of compound fractures of the cranium and compound fracture of other bones. They are not to be compared. In considering any operation we must consider the complications that may arise from it in the most skilled hands. He could hardly conceive how a serious complication could arise from an amputation of the metacarpal bone, but he could very easily understand how serious complications could arise from operative procedures upon the skull.

Referring to the fifth conclusion, he remarked that he would be very sorry to have his cranium perforated as an exploratory measure. The importance of drainage he considered well established. On the seventh proposition he differed from Dr. Roberts. Nearly all the cases of operative procedure for brain-tumor have terminated fatally. The treatment of wounds of large arteries and veins, he said, is manifest, but, he added, in all cases where there is reason to suspect that a coronal sinus has been wounded, we should act as though that sinus had been wounded. He was cognizant of one or two cases in which the patient perished before the eyes of the operator because that assumption was not made. In one case which he had seen with Dr. Hopkins, this assumption was made, with the gratifying result of averting what would have been a fatal hemorrhage. As soon as the button of bone was detached, there was a most appalling gush of blood. This was controlled by pressure and the vessel secured by suture, but great difficulty was encountered in the removal of the forceps by which the vessel was secured. Finally a piece of lint dusted with iodoform, was placed over the ligature and the case went on to recovery.

With regard to the study of cerebral localization, he agreed with Dr. Roberts, and believed that we are now fairly acquainted with the motor centres. There are few of them so well located, however, that we can be sure of the point that should be uncovered. As for the reasons for the application of the trephine he agreed in some of them with the author and differed in others, but considered the subject one that should be given more deliberate investigation. How Dr. Amidon could have obtained such a number of cases with so low a mortality as 3.6 per cent. from trephining, he could not understand. From his investigations, he would place the mortality at about 10 per cent.

As to the importance of drainage he agreed with Dr. Roberts, but not to such a degree as asserted in the paper. In regard to the temperature test, the speaker referred to its importance if it could be confirmed. In every case of which he could learn in which a record was taken, where the inflammation was confined to the brain-substance itself, the temperature was normal or subnormal. He further cautioned against waiting until

inflammation had developed before applying the trephine. After inflammation has developed, there is no good that can be done by operative procedures, unless there was a mass of pus to evacuate. The symptoms of intracranial irritation can be recognized long before there is any change but an effusion of serum.

DR. W. F. PECK, of Davenport, Iowa, said that he coincided, in the majority of instances, with the opinions expressed in the paper. The first thing to decide in accidents to the skull was whether any injury had been done to the brain, and then whether pressure was being exerted upon the intracranial contents. The secondary consequences certainly call for other interference than therapeutic. Several cases were then narrated to illustrate his views on this subject. He had had about six cases, and in their treatment he had endeavored chiefly to remove pressure and to establish drainage, which being secured, the result was, as a rule, favorable.

DR. T. F. PREWITT, of St. Louis, considered the propositions of Dr. Roberts so sweeping that they should be thoroughly discussed, and clearly defined views as to the conditions which demand trephining and those which do not demand it, laid down. He did not consider the injury in a simple case of fracture as of great importance. The danger is from the injury that may have been done to the brain. There is, however, undoubted danger in the too free use of the trephine. Some fractures of the skull are unaccompanied by symptoms, and are recovered from without leaving any permanent ill-effects, hence it is not proper to use the trephine in all cases. Those cases in which there are very sharp, needle-like spicula, are those in which the trephine should be used. Where, then, it is believed from the nature of the injury that the spicula are of this kind, as in perforating wounds, it is proper to trephine, even in the absence of very severe symptoms. Where there were no symptoms and no external wound, the speaker thought it proper to wait.

DR. C. T. PARKES, of Chicago, differed from Dr. Roberts in regard to the symptoms of compression, but admitted that it is difficult to determine to what these symptoms are due.

DR. S. W. GROSS, of Philadelphia, requested that Dr. Roberts explain, before the discussion was permitted to go further, exactly what he meant by the expression "brain symptoms."

DR. ROBERTS explained that by the term he meant the manifestations which are generally believed to come from lesions; in cases of fracture the term symptoms is generally employed to designate the coma, the hemiplegia, etc., which are usually attributed to depression of bone, or a clot upon the cerebral cortex. But in his first proposition he had tried to make clear that when we say compression we mean irritation, which is the first symptom of inflammation.

DR. PREWITT then continued his remarks by a review of the propositions of the author, and a statement of his views upon them. Referring to the location of the centre of sensation as given by Dr. Roberts, he narrated a case that had occurred in his practice. A man was struck upon the upper and outer portion of the parietal and anterior portion of the occipital bone, with the end of a pistol. There was a complete fracture. He trephined, and noticed that before the operation as

well as during it, a large amount of brain-substance was removed. After trephining, he introduced his finger and found upon the tentorium cerebri, the "sight" of the pistol. In this case the seat of sensation must have been lacerated, and in part at least removed, and yet there was not a symptom of the trouble that would be expected to follow. Two weeks later, however, the man had a chill, and became hemiplegic. This was found due to the removal of the drainage-tube, and when this was replaced the symptoms soon subsided.

DR. J. COLLINS WARREN, of Boston, referred to the difficulty of obtaining such thorough drainage as that referred to. This is chiefly on account of the intracranial tension with which we have to contend. We do not find usually large collections of pus, but get rather the symptoms of irritation from brain-inflammation without much accumulation of its products. Another difficulty in deciding the question of interference in any given case lies in the difficulties of diagnosis. We may also have brain symptoms, from lesions external to the brain, as from periostitis and cellulitis. He reported a case of fracture at the upper and anterior portion of the parietal bone, that was treated at the Massachusetts General Hospital, which had been thoroughly analyzed by Dr. Walton, the neurologist of that institution. In that case paralysis of the leg first appeared, then paralysis of the arm, and finally a paralysis of the lower portion of the face. After some time had elapsed, the symptoms began to disappear in the order of their invasion.

DR. L. McLANE TIFFANY, of Baltimore, differed from Dr. Roberts as to the insignificance of open wounds of the cranium, and remarked that most surgeons prefer to have their wounds, whether of the cranium or of other parts, remain closed. Certain monkeys, he continued, have been cited as having had their heads opened without damage, but it has yet to be shown that any man has had his head opened with as great impunity. In regard to the shattering of the inner table of the skull, he referred to the fact that it only depended upon which direction the missile took which table was shattered. He further called attention to the difference which exists between grown persons and children with regard to operative procedure, and remarked that he had seen a number of fractures in children which had gotten well without any bad symptoms, and in which the groove in the skull could be felt after the individual had reached maturity, but where a similar injury to an adult would have certainly called for operative interference. Attention was also called to a difference between the negro and the white race in regard to these operations. The negro, he said, will tolerate operations involving the brain with much less shock than the white man. He thought that the diagnosis where there were no symptoms and no depression was an impossibility. Lastly, in referring to the rules laid down by Dr. Roberts, he called attention to the direction, "brain symptoms, but no depression," and asked, "How would you know where to trephine?" There might be counter and not direct injury, and for this reason there should be a distinction made.

DR. S. W. GROSS agreed with Dr. Roberts that there might be brain symptoms with no evidence of a fracture. Such an occurrence is of extraordinary frequency in

army practice, as he remembered stating in a paper which he had prepared a few years ago on the subject of fractures of the brain in military practice. The dura mater may be so much stripped from the internal table of the skull as to give rise to an effusion of blood, and in such a case the symptoms of compression come on much more slowly than in case of the rupture of a branch of the middle meningeal artery. In regard to the simplicity of open fractures of the skull he differed from the author of the paper chiefly for the reason that the carrying out of antiseptic precautions in skull injuries is an exceedingly difficult matter. He did not consider trephining as safe as amputation of the metacarpal bone. The tables of Amidon, he stated, will not bear a critical inspection, for he has made a theory and has made his facts fit his theory, so that his paper is unreliable.

In regard to drainage, he agreed with Dr. Roberts, but added that the drainage of the brain is an exceedingly difficult thing to accomplish. In regard to the rules that are laid down, he thought it proper to make further investigation before such measures are adopted. In the case of gunshot injuries, he thought it proper to enlarge the opening and to follow the ball with large probe until its location is established, and then, if possible, to remove it. The popular sentiment with regard to the interference by the surgeon in cases of cranial injuries was also strongly denounced.

DR. E. M. MOORE, of Rochester, considered the subject one upon which the Association should give a very decided opinion. Accidents to the head are cases that are occurring to us constantly, especially in cases of suicide. What is to be done? With regard to popular sentiment, he did not think that the scientific surgeon should trouble himself about the silliness of juries, or the folly of judges. The idea of using a drainage-tube in the brain is modern, but the good results that have followed its introduction are gratifying. He has been accustomed of late to use a large probe as recommended by the last speaker, for the exploration of these wounds. In the last case in which he had used it he was able to follow the bullet down to the occipital bone, and then to trephine down upon it and remove it. He did not persevere sufficiently to carry the drainage-tube entirely through the track of the wound, as he now regretted that he did not do. The recovery in many cases is clearly attributable to the free drainage that is established by the wound, or by operation. As for the statistics of trephining, he considered them of no value whatever.

The further discussion of this paper was postponed until Wednesday morning.

MISCELLANEOUS BUSINESS.

A motion was passed inviting the Surgeon-General of the Army, the Navy, and the Marine Hospital Service, to be present, and to participate in the discussions.

DR. J. S. BILLINGS then invited the Association to take an excursion to the Johns Hopkins College and Hospital in Baltimore on Wednesday afternoon. The invitation was accepted and sufficient time set aside for the purpose.

MEDICAL SOCIETY OF THE STATE OF TENNESSEE.

*Fifty-first Annual Session, held at Nashville,
April 14, 15, and 16, 1885.*

(Specially reported for THE MEDICAL NEWS.)

THE Society was called to order in the House of Representatives, State Capitol, in Nashville, April 14th, and had a three day's session, The President, DR. D. D. SAUNDERS, of Memphis, in the Chair. There were a number of valuable papers read.

DR. R. F. EVANS, of Shelbyville, presented a paper on

MALARIAL REMITTENT FEVER,

in which he did not undertake to settle the dispute as to the name *typho-malarial*, but stated that there was a class of cases in which quinine failed to control the paroxysms. He held that in such cases it was useless to continue the use of quinine, and it was advisable to look mainly to the support of the patient. He referred to the use of tr. gelsemium and potassium bromide for the restlessness and pain, and of opium and quinine in small doses to sustain the vital functions. The paper gave rise to an animated discussion.

DR. D. D. SAUNDERS, of Memphis, attacked vigorously the hybrid term *typho-malarial*, claiming that the fever cases were either maltreated or neglected malarial fever or pure typhoid.

DR. C. C. FITE, of Nashville, stated that it was a very troublesome question but he believed that there was a malarial fever caused by a malarial germ, a typhoid fever caused by its proper *materies morbi*, and a different, distinct fever caused by decayed vegetable matter and this fever was the one under discussion. He instanced some cases in his practice in which a cistern was found to contain rotten poplar planks and also referred to the experience of Dr. Hoff, of the army; a regiment contracted this fever (called then mountain fever) from the soldiers drinking water which after leaving the snow line trickled through a bed of decaying pine-needles. He stated that some of these cases could not be called either malarial or typhoid fever, but he not only objected to the word *typho-malarial*, but believed that it was a separate and distinct disease due to vegetable decay, and held that in less than twenty years it would be so decided.

DR. O. H. MENEES, of Nashville, said that he believed in the term *typho-malarial* and instanced the ulceration of Peyer's patches and hemorrhage, stating, however, that ulcerative changes might occur from any protracted fever.

DR. G. W. DRAKE, of Chattanooga, held that the two fevers did coexist and the proper plan was to state that the case was *typhoid and malarial fever combined in the same case*. After the discussion had been continued further a committee was appointed to make a report on this subject at the next meeting of the Society, Dr. Deering J. Roberts, of Nashville, being made chairman.

DR. J. W. SHARBER, of Spring Hill, exhibited a specimen of

EXTRAUTERINE PREGNANCY,

in which the patient carried an eight months' child for twenty-nine years, and finally died from other causes.

DR. J. W. PENN, of Humboldt, read a paper on
THE CAUSES OF CHOLERA,

in which he held that people never had cholera who used pure cistern or freestone water.

DR. THOMAS L. MADDIN, of Nashville, said that the experience of Nashville proved this, for in the epidemics which had visited Nashville, and it never failed to come early and linger long there, there was always a heavy mortality for we use a strong and impure limestone water, whilst just across the river, in Edgefield, everybody uses cistern water, and they never had a case. He did not hold that impure water caused cholera, but that it prepared the system to receive the poison. Impure limestone water so impaired the vital forces that they do not resist the *materies morbi* when introduced.

A resolution was unanimously adopted memorializing the President to place the

EPIDEMIC CONTINGENT FUND

in the hands of the National Board of Health, stating that it was the proper body to attend to such matters.

DR. D. D. SAUNDERS, of Memphis, Chairman of

THE COMMITTEE ON LEGISLATION,

made a report in which he severely overhauled members of the profession who by their indifference had allowed the proposed medical bill to fail before the recent General Assembly. Tennessee has no medical law whatever, and is overrun with travelling harpies, and the profession will not unite and put a stop to it. The bill was prepared by the Committee, and afterwards rewritten and introduced by the Hon. Ernest Caldwell, of Shelbyville, and it would have become a law, but some medical men in the Legislature opposing, and not being sustained by members of the Society in the State, it failed for the lack of a constitutional majority.

DR. W. W. TAYLOR, of Memphis, Chairman of

THE COMMITTEE ON COUNTY MEDICAL ORGANIZATION, made a report in much the same strain. Another Committee was appointed, with Dr. Taylor as Chairman, to report next year.

There was a good attendance, and the meeting proved to be one of more than usual interest. The Society will meet next year, the first Tuesday in April, in Memphis, being invited to do so by the retiring President, DR. D. D. Saunders.

DR. THOMAS L. MADDIN, of Nashville, was elected President, DR. C. C. FITE, of Nashville, Secretary, and DR. DEERING J. ROBERTS, of Nashville, Treasurer.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, April 16, 1885.

THE PRESIDENT, A. JACOBI, M.D., IN THE CHAIR.

THE ANNIVERSARY ADDRESS.

THE PRESIDENT announced that the Council had appointed DR. E. G. JANEWAY to deliver the anniversary address before the Academy in November next.

PRESENTATION OF THE PORTRAIT OF LATE PRESIDENT,
FORDYCE BARKER, M.D., LL.D.

DR. THOMAS M. MARKOE, on behalf of Mr. and Mrs. John Jacob Astor, presented to the Academy

a large and admirable portrait of Dr. Fordyce Barker, painted by Lazarus. In the course of his remarks he referred to the kindly esteem in which Dr. Barker was held, as indicated by this generous gift from those who had previously testified their appreciation of the Academy of Medicine by presenting it with its "loving cup," and adding materially to its library fund.

THE PRESIDENT made an appropriate address in accepting the portrait on behalf of the Academy, in which he said that he was glad that it came from the midst of the public, and especially from those who held such an influential position in the community. It showed, as Dr. Markoe had said, that the public was beginning to take an interest in the medical profession, and to recognize the value of the services rendered by it. In the case of Dr. Barker this was certainly a well-merited homage.

DR. JAMES B. HUNTER then read a paper on
ENDOMETRITIS FUNGOSA; ITS PATHOLOGY, DIAGNOSIS,
AND TREATMENT.

The attention of the profession was first called to this condition, he said, in 1846, by Robert, a pupil of Récamier, who himself wrote of it in 1850. He then mentioned the labors of Récamier, Nélaton, Aran, Courty, Ferrier, Goldschmidt, Gallard, Winchel, Mundé, and other authorities in regard to the subject. The affection was one the importance of which had never been fully appreciated in England, but which had long been recognized in this country.

According to his own experience, Dr. Hunter said, fungosities proper were never found in the cervical canal, though they might be found immediately beyond this. They resembled small polypi, and while seldom exceeding five millimetres in diameter, were usually much smaller than this. Neither the number of the growths nor their size seemed to have any proportion whatever to the amount of hemorrhage resulting from their presence. They were of a pale pink color, had an abundant vascular supply, and there was always a distinct fibrous element in their structure. They constituted a truly inflammatory tissue, and were characterized by no process at all akin to degeneration, although Dr. Thomas, in his work on diseases of women, alluded to the condition as fungous degeneration of the lining membrane of the uterus. It had often excited remark that such profuse hemorrhage should result from such an apparently slight cause; but this was in reality not to be wondered at when the great extent of surface presented by the cavity of the uterus when studded with these growths was taken into consideration. The superficial area of the endometrium was enormously increased by the presence of even a few of them. The question of the true cause of the hemorrhage resulting from them, however, had been avoided by all writers on the subject, with whose works he was acquainted.

In making a diagnosis of endometritis fungosa, it was sometimes quite difficult to exclude sarcoma and epithelioma from the examination of a single specimen, and, hence, it was very desirable that repeated examinations should be made. Great care and perseverance were, therefore, often necessary in order to arrive positively at a correct diagnosis.

As to the symptomatology, the principal, and, indeed, only symptom of importance was menorrhagia; pain being quite rare, as a rule. In this condition the men-

strual period was likely to be increased; while in carcinoma there was a metrorrhagia, rather than a menorrhagia. Sarcoma usually did not appear until after the thirty-fifth year; but endometritis fungosa might occur at any time during the childbearing period as well as (though more rarely) both before and after the latter. The affection had no connection whatever with syphilis or gonorrhœa; but was often associated with uterine fibroids. Dr. Hunter then called attention to the differential diagnosis on the one hand between endometritis fungosa and such foreign growths as polypi, adenomata, retained decidual remains, papillomata (which were believed to be always a friend to the cervical canal, and thus occupying a distinctly different position), and the so-called villous degeneration of the endometritis referred to by Goodell; and, on the other, from malignant affections. Among the latter, round-celled sarcoma is most liable to be mistaken for it, and is not so uncommon as Dr. Mundé, in his paper sent to the Edinburgh Obstetrical Society, in 1878, and other authors had stated. In addition to microscopical differences, there are certain points by which a differential diagnosis may be made, and among these are the following: In endometritis fungosa there is little pain, while in sarcoma the pain is apt to be a prominent feature. In the one there is, as a rule, menorrhagia; in the other, metrorrhagia. In the one the discharge is odorless; in the other it is often offensive. In the one the growths are of a pale pink, and firm in consistence; in the other they are grayish-white, amorphous, and very friable. In the one there is no infiltration of the surrounding tissue; in the other there is marked infiltration and the surrounding mucous membrane is destroyed. In the one the pathological changes are confined exclusively to the mucous membrane; in the other they involve the body of the uterus also.

The treatment of the fungous growths themselves is very simple, consisting merely of their removal from the endometrium by means of the curette. The treatment of the condition which gives rise to them, however, is generally a more difficult matter, and on the success of this depends the prospect of a return of the fungosities. In his own experience he had never found it necessary to produce dilatation of the cervical canal before using the curette, as the mouth of the uterus was always sufficiently patent for the purpose. He thought it better to etherize the patient, as the growth can be more thoroughly and satisfactorily removed when this was done. Sims's speculum is placed in the vagina, and the instrument employed is the Thomas blunt copper wire curette. After the curetting Churchill's tincture of iodine is thoroughly applied to the whole endometrium, and a light tampon having been inserted, the patient is put to bed for two days.

The use of the curette has an excellent effect on the congested mucous membrane of the cavity of the uterus, even when no fungosities are present. The contra-indications for resorting to the curette are recent pelvic inflammation or the existence of any degree of parametritis. Récamier's original curette was undoubtedly a cutting instrument. It has recently been claimed in England that it is blunt; but there is in reality no evidence that such is the case.

Both Sims's and Simon's curettes are also cutting steel instruments. In the curette of Dr. Thomas, which he devised about 1870, the bluntness is the important factor, and it was the first one of the kind. Two sizes of the instrument are used. Emmet's curette-forces is an entirely different instrument. The blunt curette is perfectly safe, and as it is thoroughly efficacious in removing fungous growths, he thinks that it is greatly to be preferred in this class of cases.

DR. W. GILL WYLIE said that the pathology of the affection had been well stated, and that he was willing to accept the greater part of the paper, though he would object to Dr. Hunter's treatment in some respects. He agreed with him in the statement that the use of the curette was seldom followed by hemorrhage; and he was, therefore, somewhat surprised when he heard him say that he was in the habit of employing a light tampon after cutting. For himself, he never used a tampon if he could possibly avoid it, because he considers it a violation of one of the first laws of surgery—thorough drainage. Even in cases of cancer he prefers to stop hemorrhage in some other way. If the circular artery had been injured he would twist it with a silver wire, and under any circumstances would apply lint and cold water, styptics or pure carbolic acid, and even wait an hour before resorting to the tampon. Before antisepsics were used it was well known how offensive the tampon became, and although this may to a great extent be avoided by the use of the bichloride of mercury and iodoform, he believes there is always a liability of irritating fluid being forced up into the Fallopian tubes. He is in the habit of practising dilatation in all cases, and principally for the purpose of securing more proper drainage. In addition, though the os were quite patulous, there is always danger of injuring the cervical tissues with the curette unless further dilatation is made. He is, of course, strongly opposed to the use of sponge tents on account of the danger of septic absorption, and always uses Sims's steel dilators. He also uses Sims's steel curette, and in regard to this instrument he thought great injustice had been done Dr. Sims. The so-called sharp Sims's curette is not in reality a sharp curette, although it is true that it is made of steel. At first it was made with a flexible shank, but afterwards it was found advisable to have it constructed with an universal curve. If a tenaculum is employed in connection with the curette, any uterus can be straightened to such an extent as to admit of having the instrument satisfactorily applied to every portion of its cavity. The advantage of the steel curette over the dull copper one is, that it does the work desired more thoroughly, while at the same time it does not injure the normal tissue. In many cases he believes that the dull curette is not sufficient, because it can not remove the fungosities perfectly. Sarcoma could also be removed very thoroughly with the steel instrument.

DR. P. F. MUNDÉ said that since his paper read seven years ago before the Edinburgh Obstetrical Society, to which Dr. Hunter had alluded, had been written, cases of sarcoma have accumulated; the disease having of late become much better known than formerly. He thought that Dr. Hunter ought to have given attention to the influence of laceration of the cervix upon the causation of endometritis fungosa. He believed that it constitutes a very important element in the etiology. This is the

first link in the pathological chain which finally results in the fungous growths in the cavity of the uterus; and in restoring the organ to its normal condition it is inconsistent in the gynecologist to proceed in an inverse order. The first thing to do is to scrape away all the fungosities with the curette, and the next to apply strong tincture of iodine thoroughly to the inflamed endometrium; after which, if he repaired the laceration of the cervix there would be little danger of a return of the trouble.

Though menorrhagia was the rule with fungous endometritis, there were occasional exceptions. Dr. Wylie had mentioned amenorrhœa as being present in certain instances, and he had himself observed it in one case. The lady consulted him for amenorrhœa, telling him that she would go five or six months without any appearance of the menses, and then there would be a profuse flow. Yet, on making an examination, he found the uterus full of fungous growths. In this case, he did not employ iodine, but applied carbolic acid instead. In the paper before referred to, he had advocated the use of the short curette, and he believed that it had in reality been the means of practically introducing this instrument into Great Britain. Since the time that it had been written, however, he had modified his views, in regard to it, to some extent. While he is still an advocate of its use in many cases, he now agrees with Dr. Wylie that there are also many cases in which the blunt curette is not sufficient; the sharp instrument being required in order to eradicate the growths. In such cases it is necessary to scrape down the mucous membrane almost to the substratum. Still, he does not think it advisable to run a stiff curette, or one with which we could scrape through the uterine wall. A fairly flexible shank is preferable. The dull curette is very useful for diagnostic purposes, and if in any instance no fungosities are brought away with this, he concludes that the case is not suitable for curetting.

In regard to the after-treatment, he disagreed with Dr. Wylie and accepted the position of Dr. Hunter. When there is subinvolution there is very apt to be partly free hemorrhage, and he is often glad to plug both the uterus and the vagina. He does not believe it a good plan to curette a patient except at her own home and under the influence of an anæsthetic, and does not think it is safe to leave the house without having placed a tampon in position. After using the curette he makes an application of either tincture of iodine or of a mixture of equal parts of solution of persulphate of iron and glycerine, after which he places a tampon in the vagina. He regards this procedure in the light of an operation, and always calls within forty-eight hours to remove the tampon. Applications of iodine to the endometrium ought to be made twice a week at first, and later once a week; and he regards it as very important that the after-treatment be maintained for a sufficient length of time.

DR. C. C. LEE said he concurred, in the main, in the views expressed by Dr. Hunter. In regard to the symptomatology, however, he thought that the condition was not necessarily characterized by menorrhagia. Metrorrhagia, he believed, is a well-marked symptom in quite a large minority of typical cases; the condition of the uterus being, as a rule, one of general passive congestion. In treating endometritis fungosa he always

prepares the case carefully before operating, and when using the curette prefers to give ether. In the choice of instruments he has no hesitation in declaring himself strongly in favor of the blunt curette, as he believes the sharp curette quite as likely to do injury as good, even when employed by the most skilful hand. One of the worst cases of pelvic peritonitis, which he had ever seen, had been directly caused by the employment of the sharp curette by a gynecologist of high reputation.

He does not find it necessary to practise dilatation, as the cervical canal is always sufficiently patent in these cases. He makes it a rule always to wash out the cavity of the uterus both before and immediately after using the curette with a weak carbolic acid solution. In addition, after curetting he applies a solution of strong tincture of iodine to which is added a small quantity of chromic acid, and he had found that this combination has a much more permanent effect upon the uterine mucous membrane than any other with which he is acquainted. One part of saturated solution of chromic acid is added to four parts each of alcohol and tincture of iodine. He objected to persulphate of iron on account of the hard coagula which result from its use. The Thomas curette is the one he always employs.

DR. MUNDÉ explained that when glycerine is used with the persulphate of iron solution, as he had recommended, these hard coagula are not formed.

DR. B. F. DAWSON expressed himself as being heartily in accord with the sentiments of the author of the paper. The mildness of the dull curette constitutes its great advantage. Dr. Mundé had said that if he is unable to extract any granulations from the cavity of the uterus with the blunt curette, he does not use the sharp instrument; and if such be the case, he could not see why he should ever use the sharp one at all. Only recently he had seen a very aggravated case of pelvic cellulitis which followed the application of the sharp curette. He did not think it necessary to practise dilatation, because the whole cavity of the uterus is enlarged by the growth. Uterine catarrh is a constant concomitant of the condition of fungous granulations, and whenever uterine catarrh exists there is sure to be a patent os. He thought that ferocity was too apt to characterize the modern gynecologist.

DR. WYLIE said that the Sims's curette is not a sharp instrument in the sense of a cutting knife, and he thought that some of the gentlemen who had spoken were not familiar with it, or they would not have expressed themselves so strongly in opposition to its employment.

DR. LEE thought it strange that Dr. Wylie should make such a statement, as he himself is, and, he believed, all the other gynecologists present are perfectly familiar with the Sims's curette.

DR. HUNTER brought the discussion to a close. He said he is in the habit of using a light tampon for antiseptic purposes, and that he had not, like Dr. Mundé, found it necessary to employ it for the controlling of severe hemorrhage. Unlike Dr. Wylie, he does not believe it necessary to dilate the cervix, and this dilatation, he thought, is much more likely to do injury than the use of the curette without dilatation. He had been personally taught the use of the Sims's curette by

Dr. Sims himself, so that he is well acquainted with the instrument. He had mentioned laceration of the cervix as one of the causes of endometritis fungosa; but as it was not his intention to make his paper an exhaustive one, he had not had time to dwell upon it at length. When there is very great hemorrhage following the use of the curette in any case, he was inclined to think that it is due to the fact that all of the growth has not been removed. Like Drs. Lee and Dawson, he also had some instances in which serious consequences had resulted from the use of the sharp curette, and, at the present time, he is treating such a case in which the instrument had been handled by a skilful operator. The blunt curette should always be employed, he believed, in the condition in question; though the sharp curette also has its use, as, for instance, in the removal of carcinoma.

NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 14, 1885.

THE VICE-PRESIDENT, CHARLES McBURNEY, M.D.,
IN THE CHAIR.

DR. E. L. KEYES read a paper entitled
CASES BEARING UPON CERTAIN MOOTED POINTS IN
SYPHILOLOGY.

(See page 451.)

DR. POST asked if any irritation of the kidneys was produced by the large doses of iodide of potassium.

DR. KEYES replied, not a particle.

DR. HALL asked if the percentage in Dr. Keyes's statistics included chancroids or only indurated chancres.

DR. KEYES said that they included only chancres which had initial sclerosis; he did not think it had ever reached quite fifty per cent.

DR. GERSTER asked Dr. Keyes with regard to selection of cases by the Vienna men, if among the unicists excision is not practised indiscriminately.

DR. KEYES replied that it was. He thought the first statistics given were based on the fact that only initial sclerosis was excised.

DR. GERSTER believed that the position taken by the unicists was rational and logical, inasmuch as they admit that there is something, with reference to venereal sores, which they do not know, but which dualists claim to know and do not know. It is frequently the case that a soft chancre occurs which remains soft and yet is followed by syphilis, and one such well-authenticated observation was sufficient to overthrow the whole doctrine of dualism.

DR. KEYES said that one such authenticated case was sufficient to overthrow the entire theory of dualism if syphilis was always ushered in by hard chancre, a view which no dualist at the present time, so far as he knew, entertained. The induration of a primary chancre is very constant, but it may be entirely simulated by conditions which are not induration, so that all dualists have dropped the view that the initial lesion of syphilis is always indurated—in other words, that a given lesion is syphilitic simply because it is hard, and it is not syphilitic simply because it is soft, was not held to-day by any dualists. But that the initial lesion is generally hard, is what the dualists uphold. The absence of inguinal engorgement might as well be claimed by the

unicists as one of the irregularities in the expression of syphilis, nor did the dualists believe that the indurated chancre was necessarily a syphilitic chancre, but that it is very frequently so. The sore may be soft, the inguinal glands may be suppurating, and still the patient have syphilis. It had not been Dr. Keyes's experience to encounter a sore occurring within ten or twelve days after exposure which had turned out to be a syphilitic sore. The incubation period is one which requires great care in deciding its exact limit, and is, as Dr. Keyes thinks, a more valuable symptom of syphilis than the induration of a given sore.

DR. GERSTER said that his remarks did not refer so much to the practical study of the question as to the statement made by Dr. Keyes that the dualistic theory had brought order out of chaos. He thought that chaos had been much more firmly established by the doctrine of dualism, and that the dualistic theory is artificial and not based upon the natural history of the disease, and that it is unphilosophical. It is practically useful in most cases, to be sure, but it does not give a real and satisfactory explanation of the relation of the initial sore to the subsequent phases of the disease.

DR. KEYES said that it certainly produced practical cure, and he should be very glad to put the word practical before the words which he had used in his paper. Practically it reduces the matter to a chaotic state, to say, that all sores, whether soft or hard, are syphilitic, and reduces the surgeon logically to the necessity of treating the patient with mercury because of the fear of the development of syphilis. This is much less philosophical and less useful than the dualistic theory, which involves the use of mercury in the treatment of only one class of cases.

DR. GERSTER believed that inasmuch as it had been taught by Sigmund that syphilis should be treated symptomatically, that is, not until it manifested itself unmistakably, the objection set forth by Dr. Keyes fell away.

DR. KEYES said that it would fall away except that the natural sequence of the statement that all chancres are syphilitic would be to treat them as for syphilis. The logical conclusion of unicism, as it seemed to him, was that all sores should be treated as if they were to be followed by syphilis, which would be an error, and would have a deplorable effect upon patients in general.

DR. GERSTER: That is an error, certainly, but what we are after is the truth, and not the effect which it will produce upon the community.

DR. A. C. POST presented a specimen of

THROMBOSIS OF THE BRACHIAL ARTERY, OCCURRING FROM PRESSURE OF THE WEIGHT OF THE BODY.

The patient was a feeble man, 58 years of age, who had been bedridden for nine months with myelitis and paralysis, and loss of power over the urine and feces. Two days before death he slept with his right arm under the back, and awakened with pain and a feeling of tingling and numbness, and about an hour later the arm was seen to be white and was cold and pulseless. On the next day there was discoloration about the elbow, which in the evening had extended to the shoulder. The specimen was presented to him by Dr. Waitzfelder, and showed the upper third of the brachial artery distended with a firm clot.

FIXATION OF THE BONES AFTER RESECTION OF THE KNEE-JOINT.

DR. C. K. BRIDDON described a method which he had used, consisting in the driving in of four nails, each about three inches in length, two in the sides of the lower end of the femur, and two in the sides of the upper end of the tibia, and suturing them with copper wire. The nails should be driven in about half an inch from the cut surface, and should be left projecting about an inch and a half to prevent the copper wire from becoming buried in the integument. It was also important to approximate the skin flaps before driving in the nails. The nails were held firmly in position by making a figure of eight loop around them close to their heads, and in the two cases in which he had employed this method immobilization was complete.

DR. MCBURNEY said that the method seemed to do away with one objection which had been urged against nails, as it seemed applicable to cases in which the ends of the bones had been largely excavated by abscesses.

CORRESPONDENCE.

CHOLECYSTOTOMY AND CHOLECYSTECTOMY.

To the Editor of THE MEDICAL NEWS.

SIR: I have just read an article in your valuable paper upon cholecystotomy and cholecystectomy, in which you compare the relative advantages of the two proceedings upon figures which I think are erroneous. Thus, you give six cholecystectomies with one death, or a mortality of 16.66 per cent., whereas the fact is, according to Langenbuch himself, that there have been six cases performed, with three deaths, giving a mortality of 50 per cent. I do not think it is fair at all to estimate the value of any operation by a heterogeneous collection of cases from a number of operators, the majority of whose experience is limited to one or, at most, two cases. It is much more fair to judge of the value of the operation from the experience of one man who has had a fairly large number of cases. I have now performed cholecystotomy fifteen times without a death, and I think that that is an argument sufficient to justify me in saying that it contrasts very favorably with Langenbuch's operations in his own hands. Also that I am entitled to emphasize my previous opinion that cholecystectomy is an "intrinsically absurd operation."

I am, sir,

Yours very truly,

LAWSON TAIT.

7 THE CRESCENT, BIRMINGHAM.

April, 1885.

In the article referred to by our esteemed correspondent the figures are correct, and we invite Mr. Tait to refer us to any published or private statement in which "according to Langenbuch himself there have been six cases performed, with three deaths, giving a mortality of 50 per cent." The truth is that Langenbuch has recorded in the *Berliner klinische Wochenschrift*, Nos. 51 and 52, 1884, five cases, of which one proved fatal, in which he excised the gall-bladder. The sixth case is recorded by Courvoisier in the *Correspondenzenblatt für Schweizer Aerzte*, No. 15, 1884, so that 6 examples of cholecystectomy indicate 1 death, or a

mortality of 16.66 per cent. That this is a very fair result is shown by the fact that 36 cholecystectomies have furnished 8 deaths, or a fatality of 22.22 per cent., so that we still entertain the view that cholecystectomy is not so "intrinsically absurd" an operation as Mr. Tait still insists that it is.

As Mr. Tait has fully tested incision and drainage, we trust, in view of these correct statistics, and of the unequalled opportunities that he has in this class of cases, that he may be induced to give excision of the gall-bladder an equally fair test. When this has been done, his views, based upon actual experience, and not upon theoretical objections, will be entitled to serious consideration.—ED.]

NEWS ITEMS.

NEW ORLEANS.

(From our Special Correspondent.)

THE AMERICAN MEDICAL ASSOCIATION MEETING.—The Local Committee of Arrangements have secured the Tulane Hall and the whole of the Medical Department for the General Meetings and the Sessions of the Sections.

The General Meetings will be held on Tuesday, April 28th, at 11 A.M., and on Wednesday, Thursday, and Friday at 10 A.M. The Sessions of the Sections will be held in the seven rooms selected for the purposes at 3.30 P.M.

Registration will be attended to on the lower floor of the College building. There will be three rooms, the largest of which will be divided into four departments. The Committee will require four registry clerks, four cash clerks, one doorkeeper, one messenger, one card clerk, one postmaster, one hotel clerk. The registration office will be open on Monday from 10 A.M. to 12.30 P.M., and from 4 to 6 P.M. On Tuesday, Wednesday, and Thursday from 9 A.M. to 12 M. and from 4 to 6 P.M. On Friday from 9 to 10 A.M. On Friday, perhaps earlier, a member of the Transportation Committee will be on hand to give information as to railroads, depots, etc.

The Transportation Committee announced that the rates now in force for Exposition visitors are the best obtainable.

Exhibitors before the Association have been assigned spaces in the College building convenient to the members.

The following programme has been prepared:

TUESDAY, APRIL 28TH.—*The General Session* meets at Tulane Hall, Dryades St., between Canal and Common Sts. The Association will be called to order by Dr. Samuel Logan, Chairman of the Committee of Arrangements. After prayer, the President, Henry F. Campbell, M.D., of Augusta, Georgia, will be introduced. An Address of Welcome will then be delivered by Samuel Logan, M.D., after which the President will deliver his *Annual Address*. Austin Flint, M.D., Chairman of the Special Committee to take action in regard to the death of Prof. S. D. Gross, M.D., LL.D., will then report. New and miscellaneous business will then be in order.

The Section on Practice of Medicine, Materia Medica, and Physiology, will meet at Tulane Hall at 3.30 P.M. Dr. H. D. Didama, of Syracuse, N. Y., Chairman. The following papers will be read:

The Treatment of Carbuncle without Incision, by L. Duncan Bulkley, M.D., of New York.

Syphilis as it appears among Negroes, by Thomas F. Wood, M.D., of Wilmington, N. C.

Practical Suggestions in the Administration of Iodide of Potassium in the Treatment of Syphilis, by Morris H. Henry, M.D., of New York.

The Percuteur: Its use in Diseases of the Nervous System, by A. F. Potter, M.D., of Boston.

Hydatid Tumors of the Brain, by N. Harvey Reed, M.D., of Mansfield, Ohio.

Ulcer of Rectum, by A. Atkinson, M.D., of Baltimore.

Some Inquiry Concerning the Resources of Non-medicinal Therapeutics, by Samuel S. Wallian, M.D., of Bloomingdale, N. Y.

Section on Obstetrics and Diseases of Women and Children, Dr. R. S. Sutton, of Pittsburgh, Pa., Chairman. The following papers will be read:

The Treatment of the Secundines in Abortion and Labor, by W. H. Wathens, M.D., of Louisville.

Pelvic Peritonitis: Suggestions as to Cause, Recognition, and Treatment, by W. M. Polk, M.D., of New York City.

Chronic Periuterine Abscess, its Treatment by Laparotomy, by Christian Fenger, M.D., of Chicago.

Parametric Abscess, by W. W. Potter, M.D., of Buffalo.

How soon after Exposure to Sepsis may the Accoucheur resume Practice? By George F. French, M.D., of Minneapolis.

Section on Surgery and Anatomy, Dr. Duncan Eve, of Nashville, Chairman. The following papers will be read:

False Doctrine in the Treatment of Fractures, by John B. Roberts, M.D., of Philadelphia.

Clinical Observation on the Treatment of Varicocele, by Morris H. Henry, M.D., of New York.

Section on Ophthalmology, Otology, and Laryngology, Dr. J. A. White, of Richmond, Va., Chairman. The following papers are announced to be read:

Two New Forms of Spray Apparatus: A New Electro-cautery and New Electric Lamp, by W. C. Wile, M.D., of Sandy Hook, Ct.

Ossification of the Choroid with Sympathetic Ophthalmia, illustrated by sections of an enucleated eye, by H. B. Tiffany, M.D., of Kansas City.

Section on Diseases of Children, Dr. J. H. Pope, of Marshall, Texas, Chairman. Papers will be presented on:

Acute Inflammation of the Bones During Period of Growth, by Edward Boeck, M.D., of St. Louis.

Repeated Doses of Castor Oil in Certain Skin Diseases in Children, by L. Duncan Bulkley, M.D., of New York.

Section on Oral and Dental Surgery, Dr. W. W. Alport, of Chicago, Ill., Chairman. The following papers will be read:

Cocaine, by John S. Marshall, M.D., of Chicago, Ill.

The Alteration of Rest with Effort, by Jacob L. Williams, M.D., of Boston.

ON WEDNESDAY, APRIL 29TH, in the *General Session*, the *Address in Medicine* will be delivered by H. D. Didama, M.D., of Syracuse, Chairman of the Section on Practical Medicine, and the *Address in Obstetrics*

and Gynecology by R. S. Sutton, M.D., of Pennsylvania, Chairman of the Section of Obstetrics.

Dr. W. C. Van Bibber, of Maryland, will then make some suggestions in regard to the construction of a Health City in Florida, or, Peninsular and Sub-peninsular Air and Climate.

In the *Section on Practice of Medicine*, the following papers will be read:

A Uniform Nomenclature of the Physical Signs which Occur in Connection with the Respiratory System, by Austin Flint, M.D., of New York.

The Relation of Clinical Facts to the Question of Contagiousness of Phthisis Pulmonalis, by N. S. Davis, M.D., of Chicago.

Fever as a Neurosis, by H. C. Wood, M.D., of Philadelphia.

Mineral Foods, and how to give them, by R. J. Nunn, M.D., of Savannah.

The Treatment of Diseases by Hypodermatic Injections of Oils, by J. V. Shoemaker, M.D., of Philadelphia.

The Specific Treatment of Enteric Fever, by James C. Wilson, M.D., of Philadelphia.

Cardiography, by A. T. Keyt, M.D., of Cincinnati.

In the *Section on Obstetrics and Diseases of Women*, the following papers will be read:

A paper, the title of which is to be announced hereafter, by George J. Englemann, M.D., of St. Louis.

A New Speculum and a New Vaginal Irrigator, by T. M. Healey, M.D., of Cumberland, Md.

The Role of Bacteria in Parturition, by Henry O. Marcy, M.D., of Boston.

Vaginal Hysterectomy for Cancer, by A. Reeves Jackson, M.D., of Chicago.

The Ring of Bandl, by W. W. Jaggard, M.D., of Chicago.

A New Wire Speculum, by C. W. Wile, M.D., of Sandy Hook, Conn.

The Multiple Speculum Uteri and an Improved Dressing Forceps, by R. J. Nunn, M.D., of Savannah.

In the *Section on Surgery and Anatomy*, the papers announced are:

The Surgical Treatment of Cysts of the Pancreas, by N. Senn, M.D., of Milwaukee.

Two Successful Laparotomies on the same Patient, by Joseph Ransohoff, M.D., of Cincinnati.

In the *Section on Ophthalmology, Otology, and Laryngology*, papers will be read on

Determining Errors of Refraction by Double Images and by Parallax, by T. E. Morrell, M.D., of Little Rock.

A Case of Hereditary Glaucoma, by Herbert Harlan, M.D., of Baltimore.

In the *Section on Diseases of Children* the following papers are announced:

Successful Results of a New Treatment of Diphtheria, by R. J. Nunn, M.D., of Savannah.

The Treatment of Diphtheria in Children, by H. R. Kelly, M.D., of Gallion, Ohio.

In the *Section on Oral and Dental Surgery* papers will be read on

Epulis Tumors, by Truman W. Brophy, M.D., of Chicago.

A Case of Sarcoma of the Lower Jaw, with Successful Removal, by Oscar J. Coskery, M.D., of Baltimore.

THURSDAY, APRIL 30TH.—In the *General Session* reports will be made by the Committee of Arrangements, Committee on Nominations, and the Standing Committee on Meteorological Conditions and Their Relation to the Prevalence of Diseases. Also concerning the subject of Collective Investigations of Disease in coöperation with the Committee of the British Medical Association, by N. S. Davis, M.D., of Illinois, Chairman.

The *Address in Surgery* will be delivered by Duncan Eve, M.D., of Tennessee, and that in *State Medicine* by E. W. Schaffer, M.D., of Missouri.

The reports of the Treasurer, Librarian, and Committee on Publication will then be in order.

In the *Section on Practice of Medicine* the following papers are announced:

Cholera and its Treatment, by J. H. Hollister, M.D., of Chicago. The discussion will be opened by Dr. Austin Flint.

Hemorrhagic Malarial Fever, by Jerome Cochran, M.D., of Montgomery, Ala.

The Differentiation by Means of Pitch of Pulmonary Signs Obtained by Auscultation and Percussion, by Austin Flint, M.D., of New York.

The Germ Theory, by Harold C. Ernst, M.D., of Boston. Blood and How to make It: Fat and How to Reduce It, by Benjamin Lee, M.D., of Philadelphia.

Resorcin: Its Therapeutic Use, by A. F. Potter, M.D., of Boston.

Similarity of Electrical and Nerve Force, by J. J. Caldwell M.D., of Baltimore.

In the *Section on Obstetrics*, papers will be read on:

Treatment of the Pedicle, by Thaddeus A. Reamy, M.D., of Cincinnati.

Emmet's Operation: When shall It and when shall It not be Performed? by Gustav Zinkle, M.D., of Cincinnati.

Notes on Surgical Gynecology, by Horatio Bigelow, M.D., of Washington, D. C.

The Uterine Stem in Flexions of the Uterus, by Geo. B. F. Fundenberg, M.D., of Pittsburgh.

Reasons for, and Results of, some Cases of Tait's Operation, by S. C. Gordon, M.D., of Portland, Me.

A Report of a Cæsarean Operation, by E. W. Jenks, M.D., of Detroit.

In the *Section on Surgery and Anatomy*, Dr. A. Y. P. Garnett, of Washington, D. C., will read a paper on Colo-proctitis Treated with Hot-water Douche and Stretching or Division of Sphincter Ani.

In the *Section on Ophthalmology, Otology, and Laryngology*, Dr. J. F. Fulton, of St. Paul, Minn., will present a paper on The Relationship of Errors of Refraction to Headache.

FRIDAY, MAY 1ST.—In the *General Session*, at 10 A. M., after the reports of the Committee of Arrangements, and of the Committee on Nominations, the *Address in Ophthalmology* will be read by Dr. J. A. White, of Virginia, the *Address in Diseases of Children*, by J. H. Pope, M.D., of Texas, and the *Address in Oral and Dental Surgery*, by W. W. Allport, M.D., of Illinois.

After the transaction of miscellaneous business, the Association will then adjourn.

A committee of ladies will give a reception and ball, which promises to be the most elegant and select affair of its kind given here for a long time. Many private receptions and dinners are also proposed.

Members will be assisted in finding quarters upon their arrival, and the Bureau of Accommodation on Gravier St., opposite the St. Charles Hotel, will be of great service to those who seek rooms.

VIRGINIA.

(From our Special Correspondent.)

MEDICAL EXAMINING BOARD OF VIRGINIA.—The State Board of Medical Examiners of Virginia held its first meeting for the examination of applicants on April 8 and 9, 1885.

Under the "Act to regulate the practice of Medicine and Surgery," passed during the session of the Legislature in 1883 and 1884, all persons who propose to practise medicine in Virginia and who have not been licensed in this State at any time prior to January 1, 1885, are required to pass a satisfactory examination either before the Board in session or any three individual members of that Board whom the applicant may select. Graduates and non-graduates are subjected to precisely the same examination.

Prior to the meeting of the Board two candidates for practice had stood an examination before three individual members of the Board; one of these applicants passed a satisfactory examination, the other was rejected.

There were twenty-five applicants before the Board at its recent session, all but one of whom were graduates, of this number *nineteen* passed a satisfactory examination and *six* were rejected.

The rejected applicants are required by law to wait three months before they can again apply for examination.

There seems to have been an impression in some quarters that the examination of *graduates* would be a mere matter of form; we trust that the result of the recent examination will prove that this view is altogether erroneous.

Nearly all of the applicants were strangers to the members of the Board, and their place of graduation, if they were graduates, was known only to the President and Secretary.

THE MEDICAL ASSOCIATION OF THE STATE OF ALABAMA.—The thirty-seventh annual meeting of this association was held at Greenville, on April 14-17. The President, Dr. Benjamin N. Riggs, of Selma, in the Chair. One hundred and four members were present, being an unusually large number. The following were elected officers for the ensuing year.

President.—Dr. F. M. Peterson, of Greensboro.

Vice-Presidents.—Dr. Starr, of Wilcox County, and Dr. Richard M. Fletcher, of Madison County.

State Board of Censors.—Drs. Riggs, Dement, and Ketchum.

Councillors.—Drs. Herbert, Goodwin, Bragg, J. B. Kendrick, Norris, Wheelan, Nicholson, Lowry, and Inge.

Members of the State Board of Health.—Drs. Riggs, Ketchum, and Dement.

Orator.—Dr. Bragg, of Lowndes.

The Association voted to meet at Anniston next year.

THE AMERICAN JOURNAL OF NEUROLOGY AND PSYCHIATRY.—We regret to learn that the publication of this valuable journal ceases with the April number.

THE ATLANTA MEDICAL COLLEGE.—The annual commencement exercises of the Atlanta Medical College were held March 2, 1885. The graduating class numbered forty-one.

THE SOUTHERN MEDICAL COLLEGE.—The commencement exercises of the Southern Medical College were held March 4, 1885. Thirty-two graduates received the degree of M.D.

THE COLUMBUS MEDICAL COLLEGE held its tenth annual commencement March 3, 1885. The number of graduates was eighteen, a falling off of nearly 50 per cent. from the previous year.

CHICAGO COLLEGE OF PHYSICIANS AND SURGEONS.—The third annual commencement of the Chicago College of Physicians and Surgeons was held on March 10, 1885. The President conferred the degree of Doctor of Medicine upon sixty graduates.

THE DETROIT MEDICAL COLLEGE.—The commencement exercises of the Detroit Medical College took place in Detroit on the 2d of February, 1885. Nineteen graduates received the degree of M.D.

THE MICHIGAN COLLEGE OF MEDICINE held its annual commencement March 4, 1885. Twenty-one graduates received the degree of M.D.

A NEW MEDICAL SCHOOL IN ST. PAUL.—It appears assured that a medical school will be established in St. Paul during the present year; the St. Paul members of the Minnesota College Hospital having resigned and having received responsible promises of the necessary funds for a school in their own city.—*Northwestern Lancet*, April 15, 1885.

FRENCH SURGICAL CONGRESS.—The French Surgical Congress was inaugurated on Monday, April 6th, with Professor Trélat, President of the Committee on Organization, in the Chair.

The seven members of this committee, MM. Trélat, Verneuil, Horteloup, Chauvel, Monod, Pozzi, Bouilly, were chosen by acclamation as members of the permanent committee.

M. Trélat was elected President of the Congress for 1885. It is proposed to have an annual session.

A NEW MEDICAL CLINIC has been established at Vienna, under the direction of Professor V. Schrötter. This step of the College of Professors is generally applauded, and the appointment of Professor Von Schrötter is regarded as eminently satisfactory, and will at once inspire confidence in the operations of the clinic.

PROFESSOR HUBER will assume the position left vacant in Leipzig, by Professor Birch Hirschfeld's removal to Dresden.

PRIZE ESSAY ON THE PREVENTION OF BLINDNESS.—The English Society for the Prevention of Blindness having offered a prize of 2000 francs for the best essay on the causes and prevention of blindness, the international jury appointed to decide upon the relative

merits of the papers presented, has awarded it to Dr. Fusch, of Germany.

DIGITAL DIVULSION OF THE CARDIAC ORIFICE OF THE STOMACH.—On the 23d of February, Prof. Loreta, in the surgical clinic of Bologna, performed the operation of digital divulsion of the stomach for the seventh time with excellent result.

The condition of the patient is in every way favorable, and complete success is expected.

DR. BOUCHARDAT, Professor of Hygiene in the Paris Faculty, after a service of nearly forty years, has retired, and his name is transferred to the list of Honorary Professors.

PROFESSOR SEEGEN, who for many years has been a practitioner in Karlsbad, has abandoned the practice of medicine, in order to devote himself exclusively to physiological and experimental research.

THE JAKSCH JUBILEE.—DR. JAKSCH, whose name is so intimately connected with the Prague Medical School, celebrated on the 19th of March his fiftieth anniversary.

His excellent service as a successful clinical teacher and fame as a skilful diagnostician are recognized throughout the world, and the many congratulations received on the celebration of this jubilee are a mark of the high esteem in which he is held by his former pupils and associates.

THE HYRTL JUBILEE.—The Hyrtl Jubilee, celebrating the fiftieth anniversary of the medical career of DR. JOSEF HYRTL, took place in Vienna on the 23d of March ult. Congratulatory communications were received from all parts of the world.

Deputations comprising representative talent from the various Vienna institutions, proffered their congratulations to the venerable Professor, in addresses fitly expressing appreciation of his eminent services to science, and overflowing with assurances of esteem and goodwill. Professor Hyrtl, who is now eighty years of age, and almost entirely blind, briefly responded to the speech of Professor Zschokke, Rector of the College of Professors of the Vienna University, and also made a short address to a delegation of medical students. At the conclusion of the formalities a rich repast was served, at which Professor Hyrtl presided.

VIOLATION OF PROFESSIONAL SECRECY.—The suit against Dr. Watelet, for having divulged a "professional secret," to which we referred in our issue of April 4th, has resulted in the imposition of a fine of 100 francs.

Further evidence of the caution which should characterize the conversation of a physician in relation to his patients on points a knowledge concerning which he has gained in his professional capacity, is shown by the following, which we extract from the letter of *The Lancet's* Paris correspondent (April 4, 1885):

A physician, who was also a pharmacien, but who practised only in the latter capacity, lately died. Dr. Constantine Paul, in announcing the event at a meeting of the Société de Thérapeutique, of which the deceased gentleman was a member, stated that death was caused by tubercular meningitis, of which he had an attack ten years previously. The insurance company in which

the deceased had insured his life for 200,000 francs, or £8000, having taken note of this circumstance, has refused to pay the widow, on the grounds that her husband's life was insured subsequent to the attack he had ten years before, he being at the time the subject of a fatal malady which eventually carried him off. The case, which is interesting from more than one point of view, is pending, and it is said that if the insurance company should persist in their refusal, Dr. Constantine Paul will be prosecuted for divulging a professional secret. Examples of this kind are daily to be met with, for we see in the medical and lay papers full descriptions of maladies of persons of note, ante-mortem and post-mortem.

NOTES AND QUERIES.

HAGERDORN'S NEEDLE HOLDER AND NEEDLES.

To the Editor of THE MEDICAL NEWS.

SIR: Those desiring the above will find Frick Bros., surgical instrument makers, Ohio Street, Allegheny, Pa., prepared to fill their orders. They have my set to copy from. Some needles made in New York were shown me last week. They are not correct.

Yours truly,

R. S. SUTTON.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM APRIL 14 TO APRIL 20, 1885.

MCPARLIN, T. A., Lieutenant-Colonel and Assistant Medical Purveyor U. S. Army.—Sick leave extended three months on surgeon's certificate of disability.—*S. O. 88, A. G. O.*, April 17, 1885.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE UNITED STATES MARINE-HOSPITAL SERVICE, FOR THE WEEK ENDING APRIL 18, 1885.

YEMANS, H. W., Assistant Surgeon.—Detailed as medical officer, revenue steamer "Corwin" during cruise, April 16, 1885.

BATTLE, K. P., Assistant Surgeon.—When relieved to proceed to New Orleans, La., for duty, April 13, 1885.

BROOKS, S. D., Assistant Surgeon.—Granted leave of absence for ten days, April 16, 1885.

BAILHACHE, B. H., Surgeon.—Chairman of Board for physical examination of candidates for appointment as Assistant Engineer, Revenue-Marine Service, April 6, 1885.

VANSANT, JOHN, Surgeon.—Chairman of Board for physical examination of officers of the Revenue-Marine Service, April 11, 1885.

PURVIANE, GEORGE, Surgeon.—Granted leave of absence for one week, April 6, 1885.

STONER, G. W., Surgeon.—Member of Board for physical examination of candidates for appointment as Assistant Engineers, Revenue-Marine Service, April 9, 1885.

GODFREY, JOHN, Surgeon.—To represent Service at annual meeting of American Medical Association, April 11, 1885.

GOLDSBOROUGH, C. B., Passed Assistant Surgeon.—To proceed to Pascagoula, Miss., as inspector, April 8, 1885.

CARTER, H. R., Passed Assistant Surgeon.—Member of Board for physical examination of officers of the Revenue-Marine Service, April 11, 1885.

THE MEDICAL NEWS will be pleased to receive early intelligence of local events of general medical interest, or of matters which it is desirable to bring to the notice of the profession.

Local papers containing reports or news items should be marked.

Letters, whether written for publication or private information, must be authenticated by the names and addresses of their writers—of course not necessarily for publication.

All communications relating to the editorial department of the NEWS should be addressed to No. 1004 Walnut Street, Philadelphia.